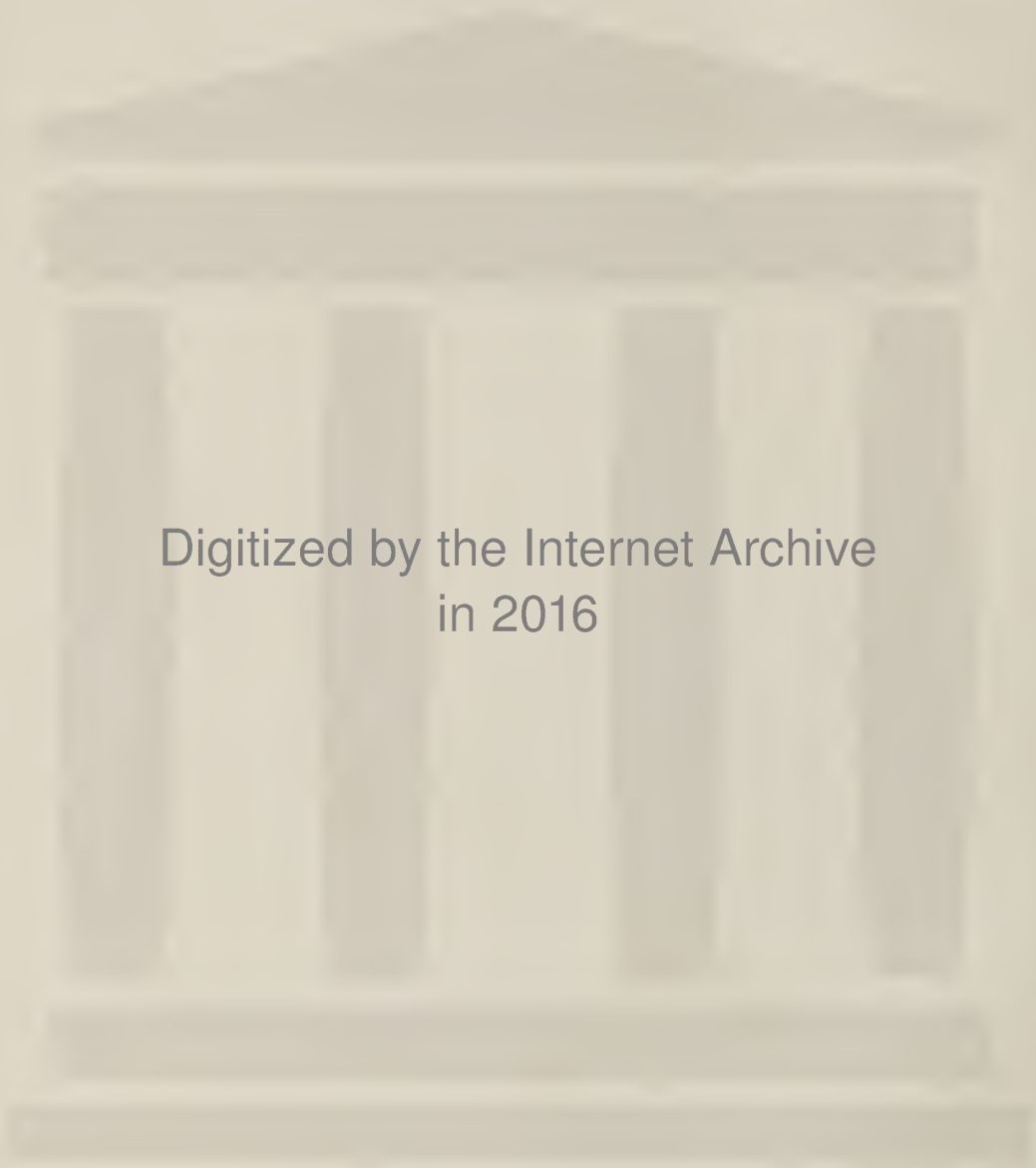

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July 1974 • Vol. 67 • No. 7 • Indianapolis, Indiana

The JOURNAL

OF THE INDIANA STATE MEDICAL ASSOCIATION

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Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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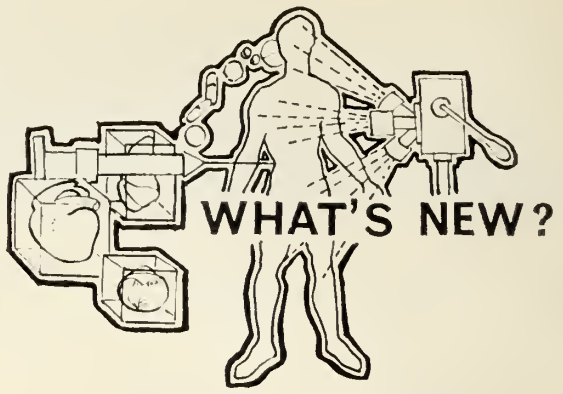
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* * *

Behavioral Publications has released "Psychotherapy and the Role of the Environment" by Harold Voth and Marjorie Orth of the Menninger Foundation. Psychotherapy has almost exclusively been concerned with the therapist-patient relationship. This book explores the effect of the environment on the patient. Hardbound—$9.95.

* * *

Specialty Merchandising of San Francisco has a new Mars Electra battery-powered small-wheeled bicycle. Said to be great for ecology buffs since it runs on electricity and can be recharged by plugging it into the house current after each trip. Makes about 25 miles between charges. Recommended for shopping trips and can also be used indoors.

* * *

Futura Publishing has released a new book, "How Modern Medicines are Discovered." It is coordinated and edited by Frank Clarke, Ph.D., of CIBA-GEIGY. The book traces the history of various illustrative medicinal breakthroughs of this century. It is aimed at science-oriented lay people and students. Price $10.

* * *

McGraw Hill has released a new book "Conception, Contraception: A New Look" which deals with human reproduction and population control. The author is Suzanne Loebel, a recognized science writer who is science editor of The Arthritis Foundation. $6.95.

* * *

News of what is new in the medical supply industry is composed of abstracts from news releases by manufacturers—of pharmaceuticals, clinical laboratory supplies, instruments and surgical appliances—and book publishers. Each item is published as news and does not necessarily constitute an endorsement of a product or recommendation for its use by THE JOURNAL or by the Indiana State Medical Association.

The patient with asthma or allergy: another type for Tylenol® (acetaminophen)



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References: 1. Modell, W., ed.: Drugs of Choice 1970-1971, St. Louis, The C. V. Mosby Company, 1970, p. 196. **2.** Goodman, L. S., and Gilman, A., ed.: The Pharmacologic Basis of Therapeutics, ed. 4, New York, The Macmillan Company, 1970, p. 327. **3.** Maslansky, L.: Paper delivered at Fourth International Congress of Allergology, New York, Oct. 18, 1961: abstracted Excerpta Med. Internat. Congress Series, No. 42, p. 124.

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JULY 1974

The Journal
of the INDIANA STATE MEDICAL ASSOCIATION

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Contributors are responsible for all statements made in their articles. The editors and editorial board members may not be in agreement with all views expressed by authors, but it is desired to give all authors as great latitude as possible.

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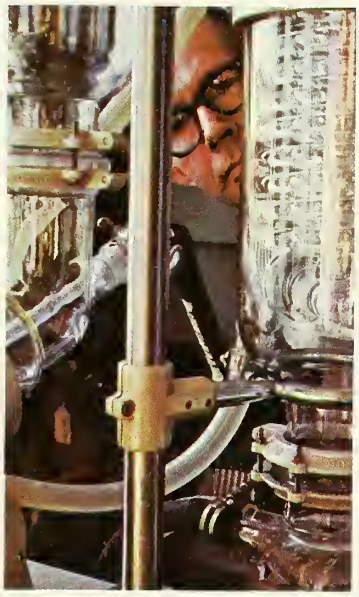
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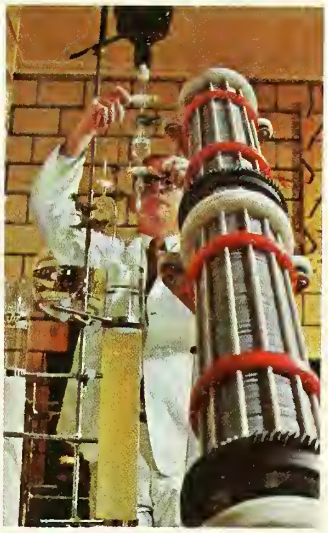
















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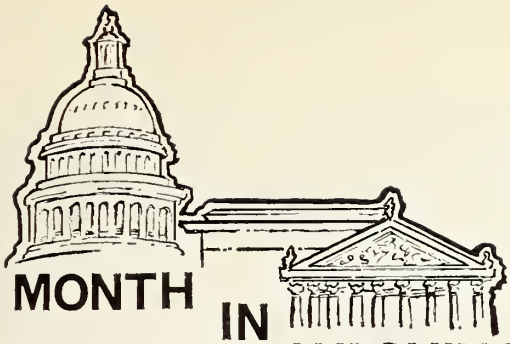
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MONTH IN WASHINGTON

This summary of what is happening in Washington is prepared by AMA's Capitol office and air-mailed to The Journal on the first of each month preceding month of issue.

With the exception of a possible last-minute catastrophic bill to the liking of both the Senate and the House, the prospects for a national health insurance (NHI) bill this year appear to be fading. Preoccupied with the possible impeachment, plus other matters, the pace of House and Senate hearings of NHI has definitely slowed, despite a strong desire on the part of both Republicans and Democrats to take a widely popular health measure with them to the polls this November.

Its late April testimony on NHI before the House Ways and Means Committee behind it, the American Medical Association again advanced its Medicredit proposal for NHI before the Senate Finance Committee at the end of May.

Senate Finance Committee Chairman Russell Long, (D-La.), and other committee members heard AMA President Russell Roth, M.D., President-elect Malcolm Todd, M.D., and Ernest Livingstone, M.D., chairman of the AMA Legislative Council, support the Medicredit measure.

"As the nation's largest association of actively practicing physicians, the ones who will be called upon to provide the professional services which are contemplated under any program which may be authorized by Congress, we feel that our viewpoints are extraordinarily important," Dr. Roth told the committee.

"If we are to meet the principal needs not only of the aged and the poor but of the vast middle-income group, it would seem we must endeavor to provide basic coverage for medical service and, if possible, add to this protection against ruinous catastrophic major medical expense (Senators Long and Abraham Ribicoff (D-Conn.) are sponsors of a catastrophic-only type NHI proposal).

"We appreciate the economies of providing only catastrophic coverage, but feel that it will meet too few of the needs and will prove very difficult to administer. We appreciate the appeal of first dollar coverage but recognize the inordinate expense involved.

"The catastrophic coverage should be adjusted to ability to pay, since it is obvious that an amount which could be easy for the well-to-do family to pay could be disastrous for the much larger group of middle and low-income individuals. If the insurance is really to protect, it must be operative at the level of need.

"If I provide $10 worth of service for my patient and he pays me directly, I have earned $10 and he has spent $10. If, instead, money is to be collected from the patient as a tax to be transmitted to Washington, processed, transferred to another agency, processed, passed on to an intermediary, processed, and paid out as a benefit, and then reviewed for appropriateness, I will need to leave it to others to estimate how much more must be collected from the patient to yield the $10 necessary to cover the service rendered. Each complicating step in the process contributes to a shrinkage in service purchased by the medical dollar.

"We believe that the public will look with dismay on a financing mechanism which increases the Social Security tax by 4%, as with the Kennedy-Mills proposal.

"We have enthusiasm for the financing mechanism in the Medicredit bill which uses tax credits to minimize the number of dollars making a round trip to Washington as tax to return as a shrunken benefit, and which places the obligation to contribute their share on those who have the ability to pay all or part of their premium cost. It uses an existing governmental collection agency, minimizes new demands for an increase in bureaucracy, and reduces administrative costs.

"Finally, there is the matter of administering the program. There is precious little evidence that any particular economy or efficiency results from government health programs, but a growing body that the opposite may be true.

"In the case of National Health Insurance, we feel assured that if any part of the funding derives from Social Security taxes there would be a compulsion for Social Security control of the program.

"We are confident that the administration of the program will best be accomplished by existing private entities in the field. Federal involvement, while inescapable when dealing with federal tax dollars, should be kept minimal.

Continued

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Alternates: A. Alan Fischer, Indianapolis; Ross L. Egger, Daleville; Kenneth O. Neumann, Lafayette.

Terms expire December 31, 1975:

Delegates: Patrick J. V. Corcoran, Evansville; Lowell H. Steen, Hammond.

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3.	Claude J. Meyer, Jeffersonville	J. L. Millan, Jeffersonville	Sept. 14-15, Clarksville
4.	A. A. Daftary, Batesville	Lanny Copeland, Osgood	Ripley County
5.	Paul Humphrey, Terre Haute	Fred Dierdorf, Terre Haute	
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9.	Milton W. Erdel, Frankfort	Harry T. Stout, Frankfort	Rensselaer
10.	Mario D. Mansueto, Munster	James R. Brown, Valparaiso	Sept. 25, Valparaiso
11.	Joseph S. Bean, Logansport	Fred Poehler, La Fontaine	Sept. 18, Logansport
12.	Franklin A. Bryan, Fort Wayne	Karl R. Schlademan, Fort Wayne	Sept. 19, 1974, Fort Wayne
13.	Jack Hannah, Elkhart	David L. Spalding, Mishawaka	Sept. 11, 1974, Elkhart

"We again believe that our Medicredit program fulfills these objectives in respect to administration more aptly than does any other proposal to date. We believe the public, in opinion poll after poll, has reiterated its high degree of confidence in the medical profession and its low esteem for bureaucratic administration. We believe that there is validity in other current public opinion polls which indicate that the chief national concern is over inflation." Dr. Roth concluded.

After Dr. Roth had read the statement, Chairman Long said he agreed with the many things that were said by the AMA official, especially the concern about wastage of funds that are channeled through Washington.

Long asked about the merits of a tax credit as opposed to a payroll tax. Dr. Roth said the tax credit is the most equitable, in that it relies on the federal income tax, which provides an accurate gauge of family income. The money retained by the individual for health insurance does not "have to make the round trip to Washington."

HEW Secretary Weinberger Urges Passage of NHI Bill

First witness before the Senate Finance Committee hearing was Health, Education, and Welfare Secretary Caspar Weinberger who urged that a NHI bill "should be the highest priority item in the closing months of this Congress." He expressed hope that the areas of disagreement between competing NHI proposals would not be found insurmountable.

The Secretary, however, criticized all the competing proposals, but with special attention to the Mills-Kennedy and the Health Security bill of organized labor. "Both vest too much power with the federal government," Weinberger said.

At the sometimes stormy meeting, Senator Vance Hartke (D-Ind.) and Senator Clifford Hansen (R-Wyo.) chided the Secretary for criticizing the AMA plan, pointing out that Medicredit had powerful backing.

Sen. Hansen said that when negotiating time arrives there should be strong consideration of the Medicredit bill, which has 182 sponsors, including five members of the Finance Committee and 11 members of the House Ways and Means Committee.

Hansen said the Council of Economic Advisors, and the Brookings Institute have recommended the tax-credit method of financing employed by Medicredit should be used in broad federal programs. Weinberger said he preferred tax credits to a Social Security payroll tax, but thought general revenue financing was best. Hansen said controls could impede productivity and cause personnel to leave the health system.

Sen. Hartke said Medicredit has more sponsors than all other NHI bills combined. Weinberger said he would keep that in mind while conferring with Congress. "You are going to have to deal with 182 of us somewhere along the line," Hartke said. "Not just 'President' Kennedy or 'President' Mills."

Hartke said that, despite Weinberger's criticism of Medicredit, the fact is that all NHI bills basically deal with financing, including the Administration's plan which doesn't provide anything concrete about changing the system.

Sen. Abraham Ribicoff (D-Conn.) said the Administration was being deceptive about the true costs of its program. He contended Weinberger is telling the American people they will have a $55 billion "free lunch."

"You are dealing with the most complex social and economic program in the history of our nation," Ribicoff said. "If all sides can't agree to work out a compromise there will be no program."

Senator Long added that Americans must be given all the facts about exactly what a NHI bill would cost them, pointing out that he couldn't ". . . see a free lunch in any of them."

Meanwhile, on the House side the Ways and Means Committee completed the second month of one-day-a-week hearings on NHI.

It would appear that almost every health related organization in the country wishes to be heard. For example, one day's hearing saw the following organizations testify before the powerful House Committee: Blue Cross Association, National Medical Association, American Osteopathic Society, National Council of Health Services, American Podiatry Association, National Council of Community Health Centers, Veterans of Foreign Wars and Americans for Democratic Action.

Some sparks flew when Andrew Biemiller, director of the AFL-CIO's Department of Legislation, appeared in place of AFL-CIO President George Meany. Biemiller, in effect, took an all-or-nothing approach, insisting that unless a bill similar to the original Kennedy-Griffiths measure is approved it would be better to wait until next year.

Of major interest to most Capitol Hill watchers is the fact that House Ways and Means Committee chairman Wilbur Mills, (D-Ark.), co-sponsor of the Kennedy-Mills proposal, attended the first hearing, but has missed all the rest.

Pressure for Congress to Pass a Bill Providing Catastrophic Coverage

Labor's stand drew criticism from committee members, some of whom stressed a theme that there is strong pressure for Congress to act this year, especially on a catastrophic bill.

Continued

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Biemiller said "If Mills-Kennedy is this committee's idea of a compromise, then I must say, in all candor, we will oppose it." Labor's strongest criticism came on the Long-Ribicoff bill. "It is not national health insurance, and does not pretend to be. It would be therefore a catastrophe if the Congress enacted catastrophic insurance," said Biemiller.

Rep. Omar Burleson (D-Texas) told Biemiller that "you are not really willing to compromise at all." He said Labor expects a Congress of a "different nature" next year so that it can get all that it wants.

Biemiller replied that the elections of 1964 changed a lot of minds in Congress about Medicare and resulted in its passage in 1965.

Congressional backers of the Medicredit national health insurance plan rallied on the floor of the House of Representatives in early May to praise the NHI approach developed by the AMA.

A score of speakers rose to urge congressmen and senators to join them in backing Medicredit, which has more sponsors—182—than all other NHI proposals combined.

"One reason why the legislation has such support in the Congress is because it is based on some solid principles that are both realistic and workable," declared Rep. Burleson.

Rep. Richard Fulton (D-Tenn.), principal co-sponsor and like Burleson a member of the key House Ways and Means committee, told the House that "Medicredit's benefits are comprehensive; its ability to meet our present needs seem unarguable; its price tag in terms of new tax dollars seems to be within the nation's means, and the method it proposes for financing the plan appears to me to rest fairly on the taxpayer without overburdening our Social Security system."

Rep. Joel Broyhill (R-Va.), chief GOP sponsor and a high-ranking member of the Ways and Means panel, said 182 members of Congress "have seen through the fog of rhetoric and printed word swirling about national health insurance. They have chosen Medicredit. I invite more of you to come aboard in support of a sensible piece of legislation."

Broyhill said Medicredit enjoys two prime virtues—free choice of health care setting and physician, and "the American philosophy of voluntarism."

Rep. Tim Lee Carter, M.D., a Kentucky Republican, said no other NHI proposal offers as liberal a psychiatric benefit as Medicredit.

The American Psychiatric Association had pointed out that Medicredit stands alone in this regard. "All other NHI proposals contain some discrimination that separates treatment of the mentally ill from that of the physically ill," noted Dr. Carter.

"Medicredit is a workable approach. The medical profession and the public want a plan that keeps the federal government's role at a minimum. From the standpoint of benefits, efficiency, financing and acceptability, I am convinced that the Medicredit approach is by far the best we have before us," Carter said.

Rep. Jerry Pettis (R-Calif.), a member of Ways and Means said his colleagues should consider foreign national health systems:

He cited such cases as:

- In Sweden the per capita health care costs increased by 614% from 1950 to 1966 compared to 174% in the United States. Since 1960 medical costs in Sweden have increased almost 900%.
- In West Germany there is a serious maldistribution of medical personnel.
- Norway reports a shortage of practitioners.
- Hospital rates in Canada are higher and length of stay longer than in the U.S.

Pettis said we had better be very careful about tinkering with our present system. "Certainly there is a clear warning in these facts to all of us that we should not abandon the strengths of the American system for the type of health delivery system which has been developed in some other country."

Rep. Peter Kyros (D-Maine) said Medicredit "goes right to the heart of the catastrophic problem. No matter how large or small a family's income, its medical expenses would never exceed 10% of that income," said Kyros. "This would be a tremendous reassurance to every family. At the same time, it offers a fair method—a sliding scale—for sharing the country's major health costs."

Rep. Robert Michel (R-Ill.) said Medicredit "meets the true test of any workable national health insurance plan—it provides access to high quality medical care to all Americans on the basis of sharing the cost in an equitable fashion. The poor would pay nothing. In a fair way, the better-off would pay on a sliding scale that reflected their income."

"Most importantly, this legislation would insure that no American would have to go bankrupt because of a catastrophic illness," said Michel.

PSRO Meeting Increased Physician Resistance

The Professional Standards Review Organization (PSRO) program is off to "an incredibly bad start" and encountering increasing physician resistance, the American Medical Association has told Congress.

AMA President Russell Roth, M.D., testifying before the Senate Finance subcommittee on health, said 13 state medical societies have formally declared for repeal of the PSRO law and that 29 societies support a policy of amendment and/or repeal. (As of May 7, 1974.)

"We cannot be precise in numbers, but it seems

Continued

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evident that, as understanding of the PSRO law spreads, the resistance to its grows," said Dr. Roth.

The health subcommittee, chaired by Sen. Eugene Talmadge (D-Ga.) slated two days of hearings on the spreading controversy over the PSRO law.

Dr. Roth said "the best efforts of the legislators involved, the staff of the Senate Finance Committee, the staff of the PSRO administrative office in HEW, and physicians from AMA, from assorted state medical societies and specialty medical organizations, have not succeeded in creating in the profession the climate of acceptance and cooperation essential to success. The fault does not lie with the sincerity or intensity of the effort to cooperate, it lies with the basic ineptitudes of the statute."

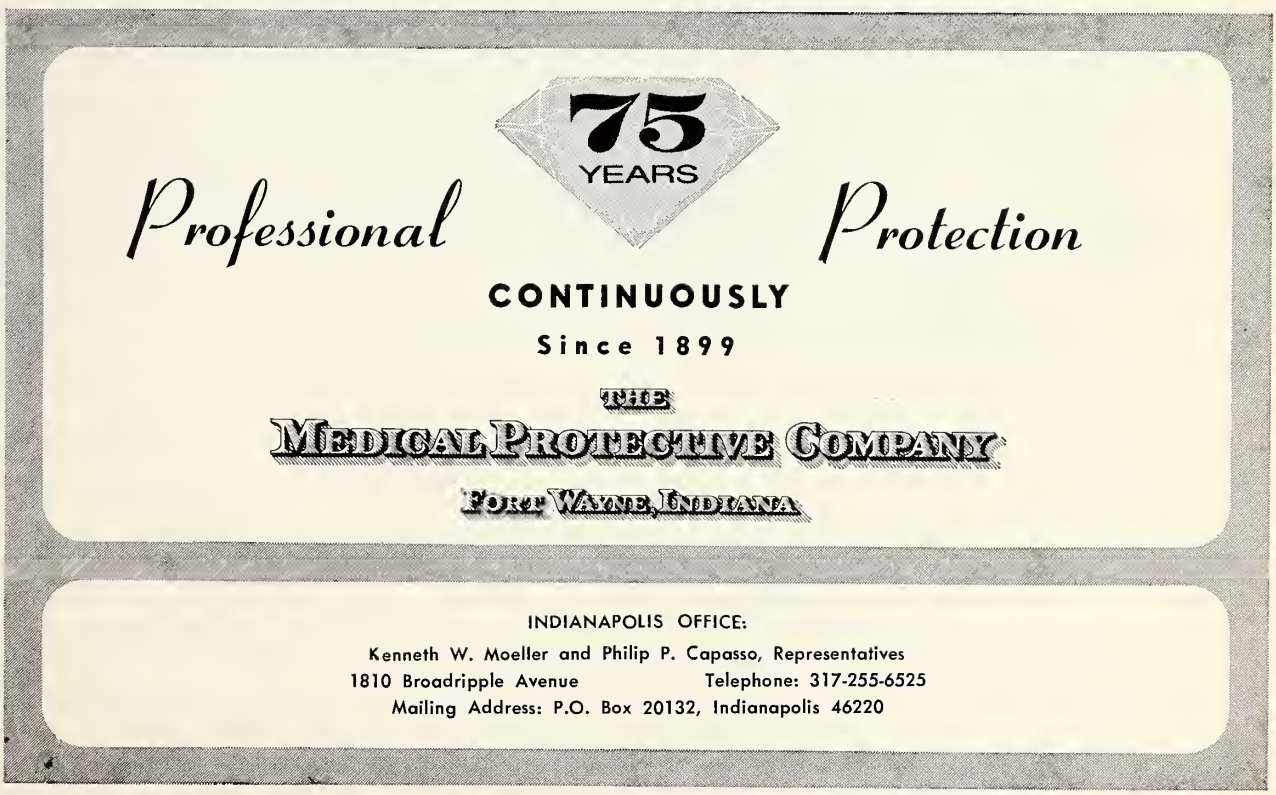
The AMA President said it has been seriously proposed that because of the bad start on PSRO it may be best to fall back, regroup, and start over again. The official AMA position, he noted, is that repeal may need to be considered if amendatory patchwork is unacceptable.

Robert Hunter, M.D., chairman of the AMA special advisory committee on PSRO and a member of the AMA board of trustees, described to the senators the AMA's extensive "constructive efforts" to cooperate with congress and the government to make PSRO work.

Edgar T. Beddingfield, Jr., M.D., vice chairman of the AMA's council on legislation, said "the PSRO law has created a great deal of confusion and misunderstanding."

Sections on norms of health care services are patently contradictory and we would anticipate that the net result would be that the norms of care would be viewed as rigid federal minimum requirements, Dr. Beddingfield said. "Patients and the profession alike are legitimately concerned with the prospect of cookbook medicine." He recommended that the "norms" should be guides for care and should be clearly understood to be initial points of evaluation and review. Furthermore, Dr. Beddingfield said, such guides must not be substituted for the medical judgment of individual physicians in the delivery of health care services.

During the two days of hearings, some 20 medical associations, state societies, and specialty groups testified their general misgivings with respect to the workability of the statute. Throughout the hearings Senator Wallace Bennett (R-Utah) stoutly defended PSRO—"I won't live long enough to see repeal of PSRO"—against, at times, shouting and hostile witnesses.



THE FAMILY LAWYER

Heroic Doctor

Two workmen digging at a construction site were buried to the waist by a sudden cave-in. A doctor, passing nearby, rushed to the scene and gave lifesaving first aid until they could be rescued by other workmen.

But the doctor himself suffered painful injuries. Was he entitled to collect damages from the construction company, on the ground that its negligence had caused the cave-in?

In a court test, the company said it was not liable.

"We admire his courage," said the company, "but anyone who ventures voluntarily into danger does so at his own risk."

However, the court said the doctor was indeed entitled to a damage award. The court said the company should have foreseen not only that workmen might be trapped but also that rescuers might rush in and get hurt too. As one judge put it:

"Danger invites rescue. The cry of distress is the summons to relief. The wrong that imperils life is a wrong to the imperilled victim; it is a wrong also to his rescuer."

Generally speaking, the law pays due respect to the heroic impulse. In fact, most courts will favor a rescuer even when the danger is merely to property, not human life.

Thus, a man injured while trying to stop a rolling automobile was awarded damages later from the car owner, who had failed to set his brakes. The court said saving property, although less urgent than saving life, is nevertheless a laudable course of action.

Still, the law does not condone outright recklessness. Another case involved a woman who was killed by a freight train while trying to pull her dog off the tracks. She had leaned over even though the train was in plain sight, bearing down fast.

Under these circumstances, a court ruled, her family could not hold the railroad responsible for the tragedy.

"A person is not excused from the consequences of his own acts in exposing himself to danger," said the court, "where the peril is so obvious."

A public service feature of the American Bar Association and the Indiana State Bar Association. Written by Will Bernard.

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Opinion & Dialogue

Is there a need for a drug compendium?

Government Health Official

Henry E. Simmons, M.D.
Deputy Assistant Secretary for Health
Department of Health, Education and Welfare



A drug compendium of the type I envision would fill a definite need for the practicing physician. Such a compendium would give him all the information necessary for using a drug intelligently, and it would do so in a clear, concise, convenient, objective and balanced fashion.

What a Compendium Should Contain

I believe the compendium should inform the doctor what a drug will do, when he should use it, for what type of patient, for how long, in what dose, what benefits his patient is likely to obtain, the risks involved, and cross-reactions with other drugs.

The information would be based on the package insert and have the same legal status. In fact, a complete compendium with complete and current information might even eliminate the necessity

Maker of Medicine

Joseph F. Sadusk, Jr., M.D.
Warner-Lambert Company



A drug compendium, or preferably compendia, should, I believe, be private, not federal, in sponsorship. They should contain comprehensive listings of drugs available for prescribing. They should be single, legibly printed volumes of reasonable size, updated quarterly or semiannually and completely revised every year.

Function of a Compendium

A compendium should furnish the following information on drugs in the following order: indications for use, side effects, adverse drug reactions, contraindications, drug interactions, drug dosage and the dosage forms marketed. Drug prices should not be included because they vary so widely and change rapidly.

No compendium should set forth drugs of choice or discuss relative efficacy. Such questions must be left for the practicing physician to decide, whether on the basis of the medical literature, his own clinical experience, advice of colleagues, information supplied by manufacturers, and so on.

Nor should a compendium undertake to educate the doctor on how to use drugs. Rather, it must be a reference source designed primarily to refresh his memory as to drugs he may not use regularly. It

or a package insert in many instances. This would constitute a substantial saving for the manufacturer.

By a complete compendium, do not mean a volume of prohibitive size. You don't need a book describing 25,000 products with an enormous amount of repetition. Rather, drugs should be arranged by class. Mutually applicable information would be provided, along with brief discussions pinpointing differences in specific drugs of that class. Listings would be cross-indexed in a useful way.

Other Available Documents as Sources of Information

Existing references such as PDR and the AMA Drug Evaluation are obviously useful but they are incomplete. Either they are not cross-referenced by generic name and do not group drugs with similar characteristics, or they do not list all the available and legally marketed drugs. And some of those omitted may be very useful.

On the other hand, drugs made by more than one supplier, tetracycline for example, may be fully described a dozen times in the same book.

While perhaps PDR could be rearranged and cross-indexed with generics included, and while the AMA Drug Evaluation might also be modified and expanded, I am not sure that the end result would have all the attributes required for a useful compendium. At the same time, you would run the risk of amassing a voluminous and unwieldy tome.

Should Editorial Comments Accompany the Listings?

Subjective judgments, in my opinion, have no place in a compendium. However, if there is substantial evidence based on a sound body of science concerning relative efficacy of several drugs, certainly that information should be included. The committee of experts compiling and editing a particular section would also have to assess and indicate instances where a meaningful difference between drugs is pertinent.

Sponsorship, Compilation and Editing

Producing a book like this would undoubtedly be difficult and demanding. It would obviously take a great deal of talent and expertise, and would require a varied and experienced group, ranging from writers and editors to highly skilled clinicians and pharmacologists. Style, format and clarity of language would play an important part in determining the usefulness of the book. And it should be updated periodically and completely revised annually.

I have no opinion whether the government or the private sector should sponsor and/or finance the compendium. What is most important is that the compendium be an authoritative, objective and useful source of information for the doctor to have at hand as a ready reference.

---

should in no way imply control over the practitioner's prerogatives.

Why Another Compendium?

A practicable, single-volume compendium cannot, nor is it necessary to, include all drugs on the market today. From my practice of internal medicine for some 15 years, my experience as a consultant, and as a faculty member of four or five medical schools, I would estimate that a doctor uses only 30 to 35 drugs regularly. The 1972 Physicians' Desk Reference, incidentally, contained about 2,500 entries.

As to whether there should be a federal compendium, in my opinion, as stated earlier, the answer is easy—there should *not* be one. The proposal assumes that existing compendia are inadequate. We're not sure of that at all. Whatever its imperfections, the present drug information system in the U.S. is open, multifaceted, pluralistic and extensive. Good compendia exist, as well as other ample sources on drug therapy, ranging from journal literature through AMA Drug Evaluation to company materials. Not all physicians may use such sources as often or as well as they should, but that is the fault of the man, not of the sources.

In any event, rather than produce another book, it makes much more sense to work on improving existing compendia, and perhaps they could, as knowledge advances, include more accumulated clinical data and experience, and more information on drug interactions and adverse reactions.

Implications of a Federal Compendium

Take a hard look at the implications of a federal compendium. It would have the force of law, virtually dictating what drugs to use and how to use them. In effect, it would be a regulatory document with legal or quasi-legal status, posing medical/legal problems similar to those the doctor may now encounter if and when he departs from the provisions of the package insert. A compendium under federal aegis would tend to restrict decisions on drug therapy to one orthodox level—a most dangerous trend for medicine.

New Compendium—A Medical Option

I detect no ground swell of initiative or support whatsoever for a federal compendium—or, for that matter, for a new compendium of any type. A 1969 PMA survey conducted by Opinion Research Corporation found that only 15 per cent of those physicians interviewed felt a new compendium was needed. And a large majority did not favor the involvement of the federal government if one were to be created, preferring instead a nongovernmental consortium.

Even if we come to a time when the medical profession itself opts for a new kind of compendium, it should be handled and financed, ideally, outside both government and industry. Final review and editorial authority could be delegated, say, to specialty bodies and medical societies—but above all, *not* the government.

Surely the health care system in the United States has far more vital matters to consider than the extensive cost and effort that would have to go into the preparation and maintenance of a new, monolithic compendium, and especially one bearing the imprimatur of the federal government.

Opinion & Dialogue

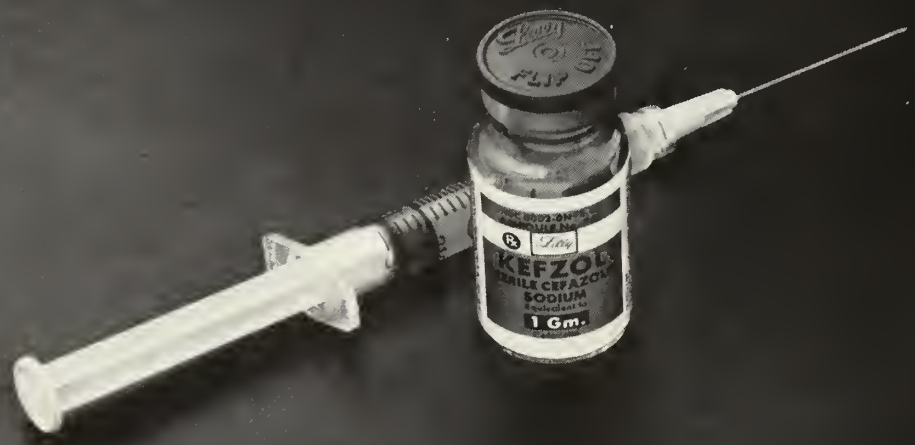
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The Journal of the INDIANA STATE MEDICAL ASSOCIATION

Volume 67—July 1974—Number 7

Fourteen cases of subclavian steal syndrome are presented including a unique congenital anomaly causing steal. Evidence from these cases is presented that shows a strong relationship between systemic blood pressure and the transstenotic gradient on which vertebral steal is dependent. A prominent role for hypertension in the production of symptomatic subclavian steal is postulated, and antihypertensive therapy is suggested as an integral part of conservative management.

The Subclavian Steal Syndrome—A Report of 14 Cases

MALCOLM HERRING, M.D.
Philadelphia

THE subclavian steal syndrome was first reported by Smyth[1] in 1866 and was further described by Reivich.[2] The usual etiology is arteriosclerotic[3] although other etiologies are reported.* To produce retrograde vertebral flow, a 20-40 torr negative gradient must exist along the artery.[2] Collateral arteries (Fig. 1) other than the vertebral may ameliorate the steal,[3,18,19] and hypertension increases the absolute transstenotic pressure gradient in dogs.[20] Fourteen cases will be presented and compared to previously reported cases; the relationship of coexistent diseases will be explored.

The clinical material presented consists of 14 patients who had angiographically documented subclavian or innominate occlusion with retrograde vertebral flow. The average age was 56 years with a range of 33-70 years. All the patients were Caucasian; 12 had an arteriosclerotic plaque; one had a traumatic and one a congenital etiology. Eight were male and six were female. The left proximal subclavian was occluded or absent in eight and stenotic in one; the right proximal subclavian was occluded in three and the innominate was occluded in one.

The presenting symptoms compare with those previously reported (Fig. 2 and Fig. 3). Eighty-six per cent had vertebral-basilar, 21% carotid, and 43% brachial symptoms; however, only one patient had any neurologic symptoms with arm exercise. One patient had a history of shoulder injury. One patient had known about his brachial anisotension for five years before he became symptomatic and another with congenital anomalies had never had symptoms. Leg claudications were complaints in 20%. The physical findings also compare with those previously reported, brachial anisotension and pulse deficit seen in 100%; supraclavicular bruit is heard in 30% (Fig. 4). Thoracic arch angiography confirmed the vertebral steal and demonstrated collateral vessels other than the vertebrals to be filling retrograde (Fig. 5).

Nine patients had operative management. All of those operated received carotid-subclavian bypass grafts as described by Diethrich.[21]

Read before the Indiana Chapter of the American College of Surgeons May 4, 1973; winner of the Willis Gatch Award.

From the Department of Surgery, St. Vincent Hospital, 2001 W. 86th St., Indianapolis 46260.

*References 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17.

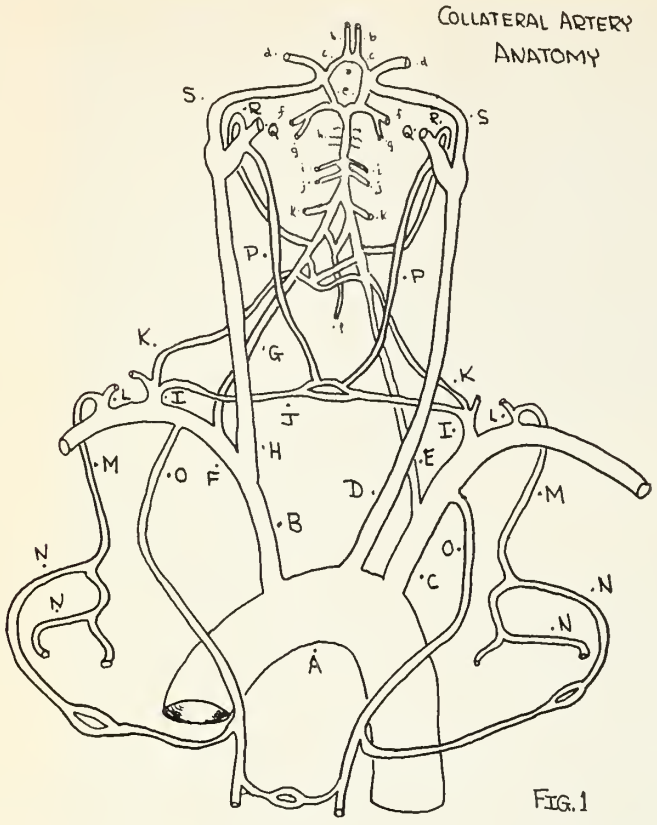


FIG. 1

ARTERIES DIAGRAMMED IN FIGURE 1

A — Aorta
B — Brachiocephalic or Innominate
C — Left Subclavian
D — Left Common Carotid
E — Left Vertebral
F — Right Subclavian
G — Right Vertebral
H — Right Common Carotid
I — Thyrocervical Trunk
J — Inferior Thyroid
K — Cervical Muscular
L — Costocervical Trunk
M — Superior Intercostal
N — Posterior Intercostal
O — Internal Mammary or Anterior Thoracic
P — Superior Thyroid
Q — External Carotid
R — Occipital
S — Internal Carotid
a — Anterior Communicating
b — Anterior Cerebral
c — Anterior Cerebral
d — Middle Cerebral
e — Posterior Communicating
f — Posterior Cerebral
g — Superior Cerebellar
h — Perforating
i — Internal Auditory
j — Anterior Inferior Cerebellar
k — Posterior Inferior Cerebellar
l — Anterior Spinal

The two exceptions included a subclavian-subclavian bypass with carotid endarterectomy,[22] and right carotid-right axillary bypass. All but three were bypassed with eight mm Dacron knitted graft; two received Dacron velour, and one received a Teflon graft. The vertebral artery was ligated in two patients.

The complications encountered in this series include two patients with postoperative anemia, two with serum collections in the wound despite routine Hemovac drainage, two with pulmonary problems, two with short-term persistence of brachial anisotension, two with graft occlusions (one intraoperatively and one with Teflon graft two weeks postoperatively), one with hoarseness of two weeks' duration, and there was one death in renal failure.

The coexistent diseases noted during the patients' evaluation (Fig. 6) show a predominance of cigarette habit and hypertension. The possible contribution of these diseases to the subclavian steal was examined. Cigarette consumption was associated with an adverse trend in the degree of brachial anisotension (Fig. 7), and the availability of collaterals visualized angiographically. The degree of hypertension was found to have an adverse association with collateral availability (Fig. 8). Most important to the pathophysiology of vertebral steal is the fact that increasing hypertension results in increasing brachial anisotension (Fig. 9). Males, those having evidence of arteriosclerotic cardiovascular disease, and those having pulmonary emphysema, had significantly ($p<0.01$) greater brachial anisotension and also had

Symptom Frequencies in Various Series

SYMPTOM	KILLEN[25]	EWING[26]	THIS	TOTAL
Motor Deficit	31	10	2	43
Dizziness	29	7	8	44
Visual Defect	25	5	1	31
Syncope	21	1	4	26
Cephalalgia	13	5	5	23
Vertigo	11	4	2	17
Ataxia	9	1	3	13
Paresthesia	8	10	0	18
Dysarthria	8	1	1	10
Diplopia	8	2	2	12
Aphasia	6	0	1	7
Memory Loss	5	2	1	8
Nausea, Vomiting	5	2	2	9
Confusion	4	1	2	7
Focal Seizure	2	0	0	2
Olfactory Halluc.	1	0	0	1
Tinnitus	1	1	1	3

FIG. 2

fewer available collaterals.

The follow-up of the nine patients requiring surgery revealed resolution of the anisotension in each of six patients in which measurements were available. In three, postoperative angiograms were done which showed graft patency in all, with moderate suture line stenosis in only one anastomosis. Symptom resolution was reported in each of the nine; the longest follow-up, at 24 months, revealed recurrence of the left vertebrobasilar symptoms and signs but without brachial anisotension.

Discussion

A great male predominance was not seen; however, a significantly greater brachial anisotension was seen among the males. An unreported congenital anomaly creating vertebral siphon was seen in this series with atresia of the left proximal subclavian origin, intact left carotid and right carotid originating directly from a right thoracic aortic arch. The presenting symptoms were not unusual except for one patient with emotional incontinence, possibly representing corticobulbar tract or basal ganglion involvement, both areas subtended in part by the posterior circulation. Minor psychiatric complaints were spontaneous in 36%, occurring more frequently than any central nervous system complaint other than dizziness. The high correlation of brachial anisotension and angiographically proven steal is corroborated. The frequency of aortoilliofemoral disease is found to be comparable to that reported by Thompson.[16] Collaterals other than the vertebral-vertebral route proved to be angiographically more prominent than reported by Lord.[23] None of the Willis' Circle configurations reported by Lord were seen with any remarkable frequency in this series. None had the so-called "embryonic" posterior communicating artery and only one patient filled the posterior circulation from the carotid. Among the associated diseases, a cigarette habit was seen in 79% with significant increase in brachial anisotension, corroborating

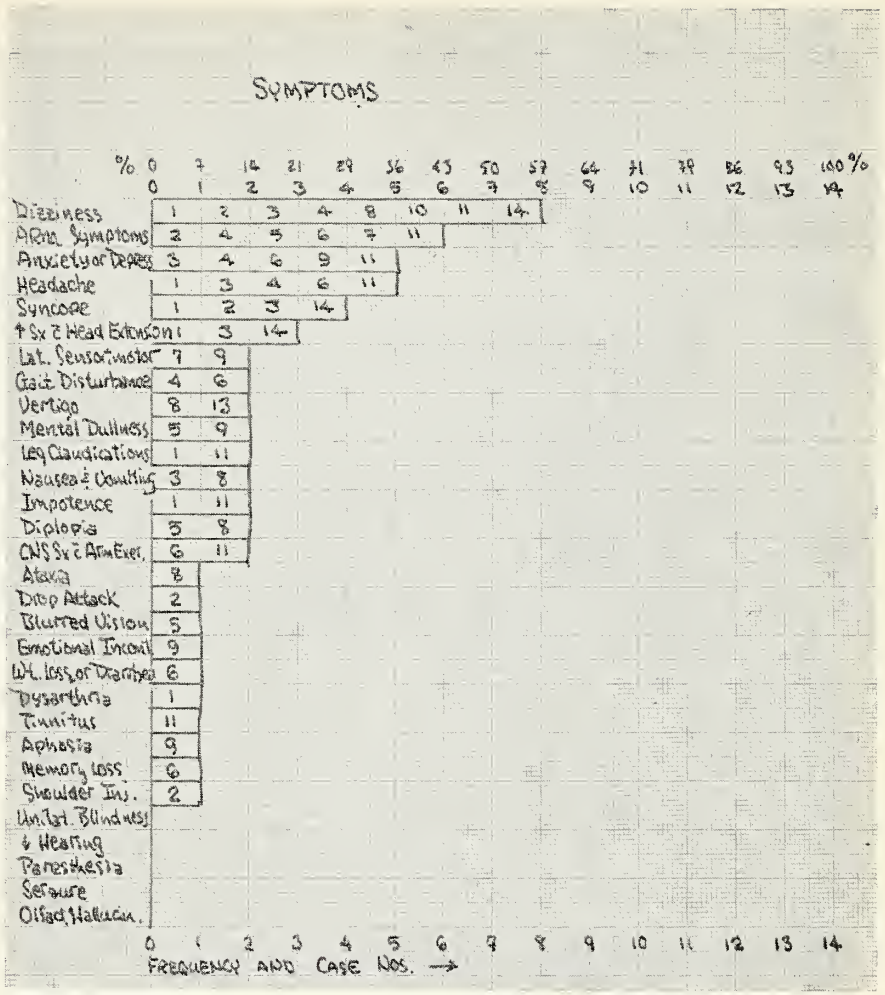


FIG. 3

Thompson's previous correlations of smoking and subclavian steal[16] and underlining the contribution of cigarettes to arteriosclerotic disease.[24] The increase in anisotension among patients with arteriosclerotic cardiovascular disease probably reflects a greater extent of the underlying disease, and possibly the propensity to low cardiac output may contribute to the paucity of collaterals. The occurrence or history of inguinal hernia in 21% (37% of the males) is probably related to the frequency of chronic bronchitis and emphysema.

Either systolic or diastolic hypertension was seen in 64% of the patients, a group with significantly greater anisotension. Since a gradient of 20-40 torr is required to create retrograde vertebral flow,[2] and since a cause-effect relationship of hypertension to steal is suggested by the data in Fig. 9, an attempt should be made to control hypertension before deciding on surgical management. The patient may thereby be rendered asymptomatic and the steal possibly ablated. Second, higher blood pressures were associated with a diminished number of available collaterals. Third, hypertensive arteriolar changes may be reversed with hypertensive control, possibly helping to resolve symptoms. In treating, the hypertension drugs which widen pulse pressure should be avoided when possible. If transient ischemic episodes, minor neurologic complaints or symptoms of brachial artery insufficiency persist after concerted medical effort, carotid-subclavian or subclavian-subclavian bypass should be undertaken.

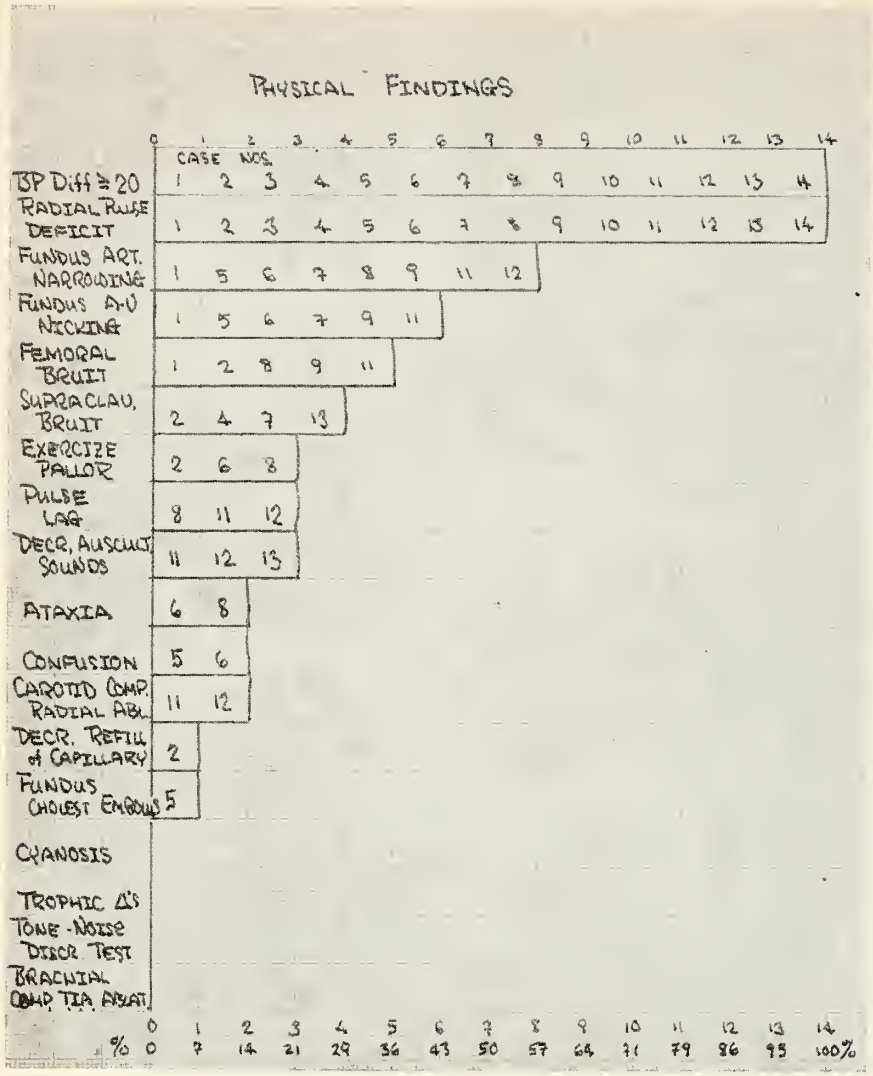


FIG. 4

Summary

Fourteen cases of subclavian steal syndrome are presented, including a unique congenital anomaly causing steal. Evidence from these cases is presented that shows a strong relationship between systemic blood pressure and the transstenotic gradient on which vertebral steal is dependent. A prominent role for hypertension in the production of symptomatic subclavian steal is postulated, and antihypertensive therapy is suggested as an integral part of conservative management.

Acknowledgements

To Austin Gardner, M.D., surgical staff, St. Vincent Hospital, for his counsel; and to Edward Wheeler, M.D., radiology staff, St. Vincent Hospital, for his interpretations of the roentgenograms, my thanks.

BIBLIOGRAPHY

1. Smyth, A., Successful Operation in a Case of Subclavian Aneurism, Original Communications, Article II, *New Orleans Medical Record* 1:4, May 15, 1866; Reprinted in *Stroke* 1:320-324, 1970.

2. Reivich, M., Reversal of Blood Flow through the Vertebral Artery and its Effect on Cerebral Circulation. *N. Engl. J. Med.* 265:879-885, 1961.

3. Piccone, V., The Subclavian Steal Syndrome, *Ann. Thorac. Surg.*, 9: 51-75, 1970.

4. Agee, E., Two Unusual Cases of Subclavian Steal Syndrome, *Amer. J. Roentgenol.* 97:447-457, 1966.

5. Blalock, A., The Surgical Treatment of Malformations of the Heart in which there is Pulmonary Stenosis or Pulmonary Atresia, *JAMA* 128: 189, 1945.

6. Boudin, G., Syndrome de l'artère sous-clavière voleuse, Fréquence des lésions carotidiennes associées, *Rev. Neurol.* (*Paris*) 121:195-199, 1966.

7. Dardik, H., Subclavian Steal Syndrome Secondary to Embolism, *Ann. Surg.* 164:171-174, 1966.

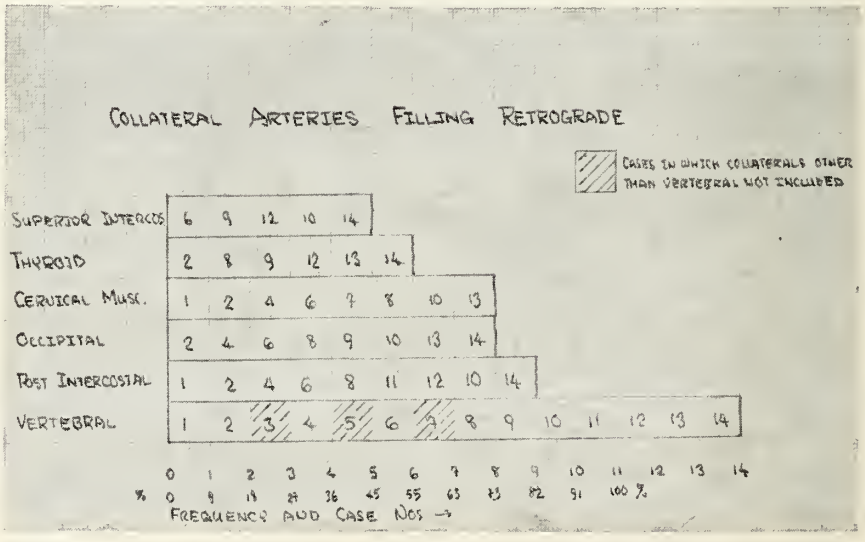


FIG. 5

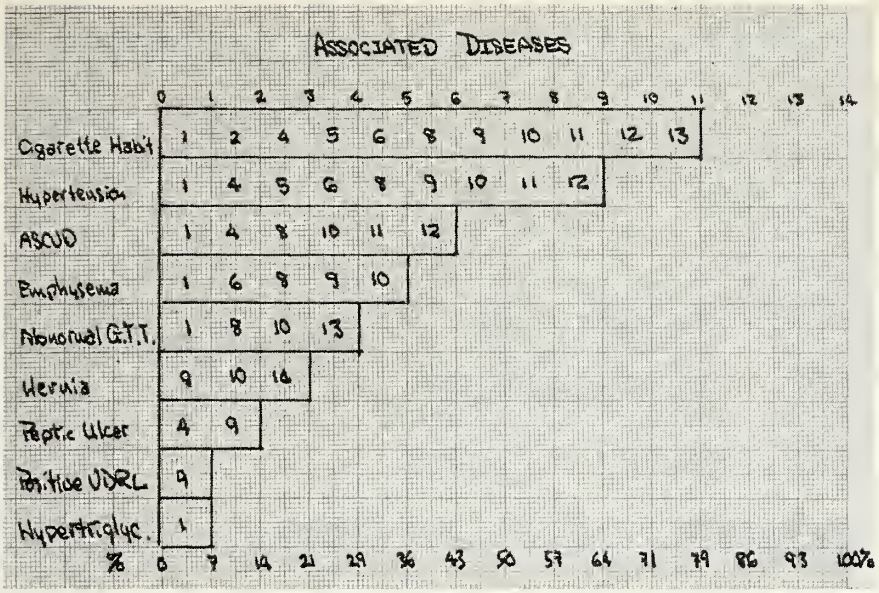


FIG. 6

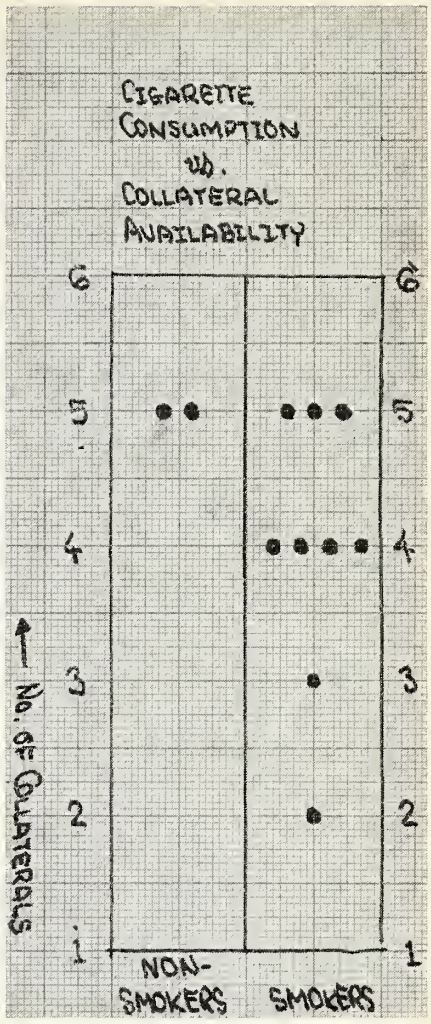


FIG. 7

8. Daves, M., Vertebral Grand Larceny, *Circulation* 29:911-913, 1964.
9. Gonzales, L., Retrograde Flow in the Vertebral Artery, *Arch. Surg.* (Chicago) 91:185-194, 1965.
10. Grollman, J. Jr., Roentgen Diagnosis of Takayasu's Arteritis, *Radiology* 83:387-395, 1964.
11. Gumrich, H., Beobachtungen beim Takayasu-Syndrom, *Arch. Klin. Chir.* 122:316-317, 1966.
12. Leicht, E., Traumatisches Subklavia-Entzugssyndrom, *Fortschr. Geb. Roentgenstr. Nuklearmed.* 112:629-633, 1970.
13. Levine, S., Right Aortic Arch with Subclavian Steal Syndrome, *Am. J. Surg.* 111:632-637, 1966.
14. Massumi, R., The Congenital Variety of the 'Subclavian Steal' Syndrome, *Circulation* 28:1149-1152, 1963.
15. Rojas, R., Acute Traumatic Subclavian Steal Syndrome, *J. Thorac.*

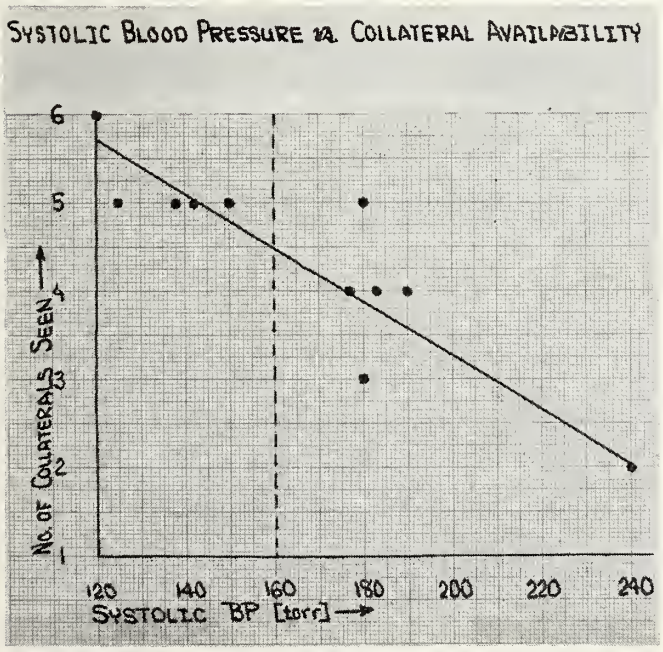


FIG. 8

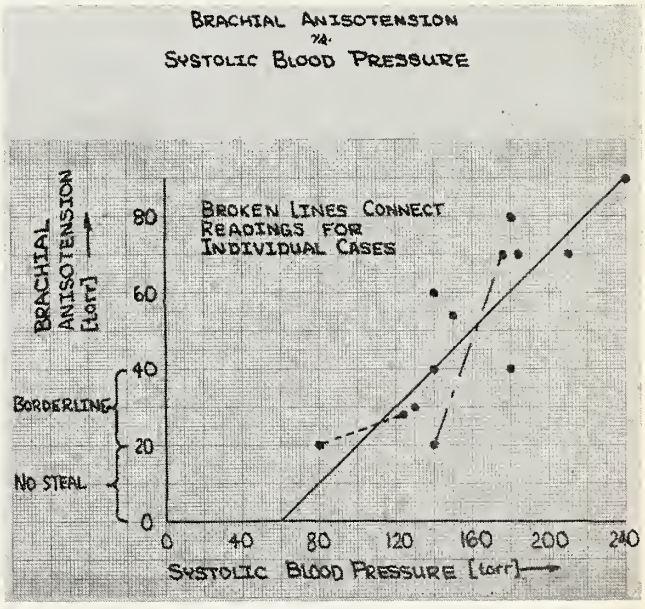


FIG. 9

Cardiovasc. Surg. 51:113-115, 1966.
16. Thompson, B., Incidence of the Leriche Syndrome in Patients with Subclavian Steal, *Am. J. Surg.* 122: 666-668, 1971.
17. Toole, J., Subclavian Steal Syndrome —Reversal of Cephalic Blood Flow, *Medicine* 44:289-303, 1965.
18. Bettelheim, H. Augenveränderungen beim Subclavian Steal Syndrom, *Wien. Klin. Wochenschr.* 82:142-143, 1970.
19. North, R., Brachiobasilar Insufficiency Syndrome, *Neurology* 12: 810-820, 1962.
20. Sammartino, W., Reversed Vertebral Artery Flow, *Arch. Neurol.* 10:590-594, 1964.
21. Diethrich, E., Occlusive Disease of the Common Carotid and Subclavian Arteries Treated by Carotid-Subclavian Bypass, *Am. J. Surg.* 114: 800-808, 1967.
22. Finkelstein, N., Subclavian-Subclavian Bypass for the Subclavian Steal Syndrome, *Surgery* 71:136-141, 1972.
23. Lord, R., Contribution of the Circle of Willis to the Subclavian Steal Syndrome, *Circulation* 40:871-878, 1969.
24. Sackett, D., Relation between Aortic Atherosclerosis and the Use of Cigarettes and Alcohol, *N. Engl. J. Med.* 279:1413-1420, 1968.
25. Killen, D., The Subclavian Steal Syndrome, *J. Thorac. Cardiovasc. Surg.* 51:539-560, 1966.
26. Ewing, D., Subclavian Steal Syndrome, *Vasc. Surg.* 5:137-147, 1971. ◄

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Animal Bites	1019	968	829	1038	1277
Chickenpox	668	517	688	715	658
Conjunctivitis	216	155	249	336	254
Diphtheria	0	0	0	0	0
Dysentery, Unspecified	65	99	131	27	22
Gonorrhea	910	918	1327	796	634
Impetigo	122	91	162	112	80
Infectious Hepatitis	82	57	70	41	53
Infectious Mononucleosis	73	102	98	59	126
Influenza	2561	3717	10226	1310	705
Measles					
Rubeola	41	44	38	100	219
Rubella	54	31	102	153	103
Meningococcic Meningitis	1	4	2	1	1
Meningitis, Other	2	4	1	1	1
Mumps	137	94	158	151	126
Pertussis (Whooping Cough)	4	1	2	1	79
Pneumonia	392	636	812	545	357
Poliomyelitis	0	0	0	0	0
Streptococcal Infections	1595	1697	1882	1469	1114
Syphilis					
Primary & Secondary	15	21	9	17	14
All Other Syphilis	103	120	125	84	85
Tinea Capitis	18	14	13	5	2
Tuberculosis (Active)	41	42	49	75	57



FIGURE 5

The large intraluminal mass seen on entering the second portion of the duodenum (see arrows). Photograph taken through a Model GIF Type D Olympus Gastroduodenoscope.

ERRATUM

The photograph which is reproduced here in color appeared inadvertently in black and white in the May issue of The Journal as an illustration for the article by Drs. Bernard D. Rosenak, Stanley M. Chernish, John A. Robb and Roscoe E. Miller, Indianapolis, entitled "Intraluminal Diverticulum of the Duodenum: Report of a Case with Roentgenologic and Endoscopic Appearance," pages 325-328. While the color reproduction is not quite of the quality desired, it is here presented in the belief that the illustration is much more meaningful in color.

The Journal regrets its failure to carry the photo in color when the article was published in May and apologizes to all concerned.

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Complete literature available on request from Professional Services Dept. PML.

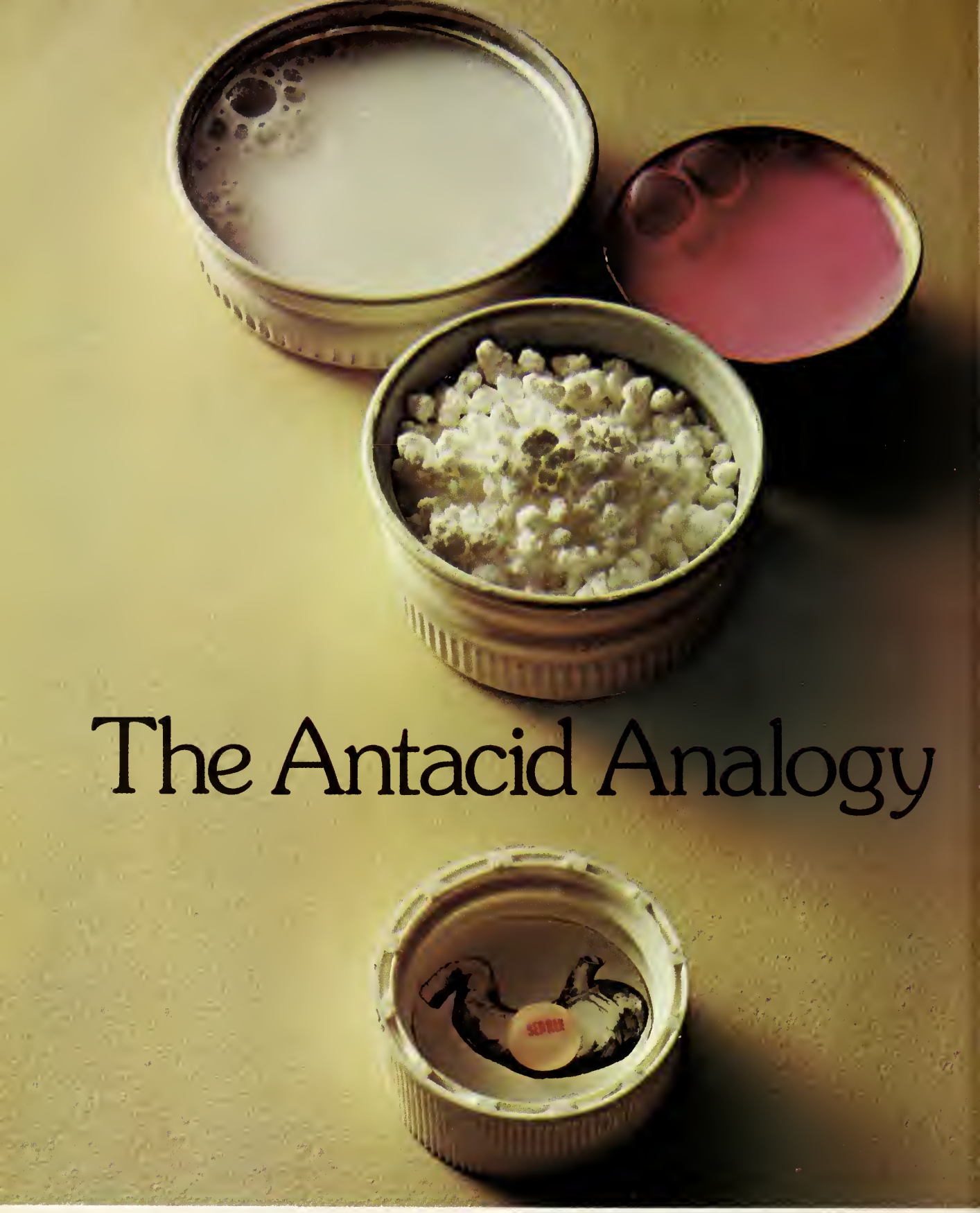
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*Innes, I. R., and Nickerson, M., in Goodman, L. S., and Gilman, A. (editors): The Pharmacological Basis of Therapeutics, ed. 4, New York, The Macmillan Company, 1970, p. 537.

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ccur as well as mydriasis and blurred vision. In addition the following dverse reactions have been reported: nervousness, drowsiness, dizziness, nsomnia, headache, loss of the sense of taste, nausea, vomiting, constipa- on, impotence and allergic dermatitis.

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Warnings: Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired. Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, **check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently**—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect.

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*Serum Potassium Level Drops During Long-Term Exercise, *Medical Tribune*, July 4, 1973.

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Urinary Tract Infections in Newborns, Infants and Children

J. D. NORTHWAY, M.D.
S. K. ANAND, M.D.
N. J. HIRSCH, M.D.
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URINARY tract infections (UTIs) are by far the most common renal disorder in childhood. The urinary tract is the second most common organ system, after the respiratory tract, in which bacterial infections localize. Many UTIs are not accompanied by the familiar symptoms of costovertebral angle tenderness, fever, chills, frequency and dysuria. Instead they are asymptomatic or associated with symptoms which are so nonspecific that the unsuspecting physician may not consider the diagnosis of a UTI. In some children UTIs are a nuisance disease with no evidence suggesting progressive renal damage.

In others UTIs may be responsible for the serious and permanent kidney damage recognized as chronic pyelonephritis. The sequence of events which leads to chronic pyelonephritis and possible renal failure is still not completely understood. Thus, the early detection, appropriate management and subsequent follow-up of the child with a UTI represents a real opportunity to practice preventive medicine.

In any given child localization of the infection to the lower urinary tract, bladder or urethra is extremely difficult. This paper will not attempt to differentiate between urethritis, cystitis and acute pyelonephritis. We think it is safer to assume that any child with significant bacteriuria is infected from the tip of the urethra to the medulla of the kidney.

What Is a Urinary Tract Infection?

In order to understand the approach to the patient with a UTI, the concept of significant bacteriuria must be understood. The urine in the renal pelvis, ureter and bladder is normally sterile. Theoretically, then, the presence of any bacteria in the urine is significant. This last statement would be true if the urine could be collected without contamination. Unless the urine is obtained by percutaneous bladder aspiration, some contamination of the specimen is almost inevitable. This contamination may be urethral, vaginal, periurethral or fecal. Thus the term "significant bacteriuria" was introduced to aid the physician in differentiating a UTI from a contaminated urine culture.

In determining significant bacteriuria one must know how the sample was collected. Urine obtained by percutaneous bladder aspiration or by aseptic retrograde collection from the renal pelvis, ureters or bladder is almost always sterile. In practice, however, most culture samples are taken from voided urine. In several large studies contamination of voided samples seldom exceeded 10,000 bacterial colonies/ml of urine. In patients with the clinical symptoms of a UTI, 100,000 or more bacterial colonies/ml of urine, will be found in 95% of cases. In asymptomatic patients subsequently shown to have a UTI, one culture of $\geq$ 100,000 colonies/ml represents an 80% confidence limit that the patient is infected. Three consecutive specimens containing $\geq$ 100,000 colonies/ml represents a 95% confidence limit. In asymptomatic patients a single

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Supported by the James Whitcomb Riley Memorial Association.

catheterized specimen containing ≥ 100,000 colonies/ml also has a 95% confidence level. However, a single catheterization may introduce infection in 1-3% of patients with a normal urinary tract. The incidence of introducing infection with a single catheterization may be higher in children with urinary tract abnormalities. Using the percutaneous bladder aspiration technic to obtain urine, bladder sterility approaches 99% confidence limits in non-infected individuals. Serious complications from this procedure are rare.

In Table 1 are set forth the guidelines to aid in the interpretation of urine culture results. In a symptomatic patient one or more clean voided urine cultures containing ≥ 100,000 organisms/ml are significant. In an asymptomatic patient at least two consecutive clean voided cultures containing ≥ 100,000 organisms/ml, three consecutive cultures containing ≥ 50,000 organisms/ml, one single catheter specimen containing ≥ 100,000 colonies/ml or a single suprapubic bladder puncture containing 5,000 or more colonies is significant. A significant culture should contain only one bacteria type unless the urinary tract has been recently instrumented. Repeat cultures should reveal the same type of bacteria.

TABLE 1

Minimal Bacteriologic Criteria to Establish Diagnosis of a Urinary Tract Infection

Symptomatic male or female

1. One clean voided urine specimen with ≥ 100,000 colonies/ml urine.

Asymptomatic female

1. Three consecutive clean voided specimens with ≥ 100,000 colonies/ml urine. All three cultures must contain the same organism.*

or 2. Three consecutive clean voided specimens with ≥ 50,000 colonies/ml urine. All three cultures must contain the same organism.*

or 3. One urethral catheter specimen with ≥ 100,000 colonies/ml urine.

or 4. One suprapubic bladder puncture revealing any number of colonies. Counts generally ≥ 5,000.

*In hospital patients or asymptomatic males two consecutive specimens with ≥ 100,000 colonies/ml urine is satisfactory.

Follow-up Patients

1. One clean voided specimen with ≥ 100,000 colonies/ml urine.
2. Two clean voided specimens with 10,000 to 100,000 colonies/ml of urine. Both cultures must contain same organism.

Clinical Spectrum of Urinary Tract Infections in Newborns, Infants and Children

UTIs occur throughout childhood but the incidence is greatest in infants and preschoolers. Thus, early detection is extremely important if we are to protect the growing kidney from the potential damage of bacterial infections.

I. *Newborn Period*

Urinary tract infections in the newborn period have several unique characteristics. In this age group males predominate by a 3:1 ratio over females. The majority of these infections appear to be blood borne rather than acquired in the retrograde fashion as in later life. The third interesting feature of UTIs at this age is the low incidence of obstructive urinary tract malformations. Prominent symptoms in infected newborns are listed in Table 2. Note that none of the symptoms specifically points to the urinary tract. This is not surprising, as most of the symptoms we classically associate with urinary tract infections must be vocalized—i.e., frequency, dysuria, urgency and abdominal pain.

II. *Infants and Preschool Children*

Nonobstructive UTIs in infants and young children are 10-20 times more frequent in females. The infections are thought to originate in a retrograde ascending manner. Males with UTIs in this age group often will be found to have an obstructive urinary tract abnormality. The symptoms associated with urinary tract infections in this age group are depicted in Table 3. Fev-

TABLE 2

Urinary Tract Infection Manifestations in Newborns

Unsatisfactory weight gain or excessive weight loss
History of poor feeding or lethargy
Fever
Cyanosis, pallor or gray skin color
Vomiting and diarrhea
Central Nervous System symptoms: Convulsions, hypotonicity, irritability, sluggishness and respiratory irregularities
Jaundice

TABLE 3

Common Urinary Tract Infection Manifestations

INFANTS AND PRESCHOOLERS
Fever or fevers of unknown origin
Failure to thrive
Unsatisfactory weight gain
Enuresis in previously trained child
Abdominal pain
Frequency and dysuria
SCHOOL AGE CHILDREN
Fever—less frequent than in younger children
Dysuria, frequency, enuresis
Flank pain, suprapubic pain or vague abdominal discomfort

er, failure to thrive and abdominal pain are common complaints. Rather than vocalize dysuria, the child will often grab her perineum or suprapubic area when she has to void.

III. *School Children*

UTIs in this age group are 30 times more frequent in females than males. According to Kunin's data, at any given time 1.2% of school girls will have significant bacteriuria. Five to 6% of all girls will have at least one UTI between entering the first grade and graduation from high school. In symptomatic infections fever, frequency, urgency, dysuria and enuresis are common complaints. It should be emphasized that asymptomatic infections are very prevalent in this age group. In Cohen's series there was a noticeable decrease in symptomatology with increasing age. Asymptomatic infections were three times more frequent in children over the age of five.

Laboratory Diagnostic Aids

A. *Urinalysis*

I. Odor and Appearance

The presence of a fishy or strong smell to the urine has been reported to be suggestive of significant bacteriuria. Cloudy urine is generally not a helpful observation. Gross hematuria is an uncommon manifestation of a UTI. If present, gross hematuria is most often associated with symptoms suggesting lower urinary tract infections. In this clinic patients presenting with gross hematuria are first considered to have some type of glomerulonephritis rather than pyelonephritis or cystitis. Proteinuria in an uncomplicated UTI is either absent or minimal. The presence of significant proteinuria may be evidence of advanced renal pathology.

The microscopic evaluation of the fresh urine sediment may add some useful information in establishing the diagnosis of a UTI. In the uncentrifuged urine sample, the finding of three to four bacteria per high power microscopic field correlates well with a significant colony count. However, at times the urine will be teeming with bacteria but the urine culture will be reported as no growth. In this situation the bacteria which were seen were probably contaminants from the introitus or vagina. Bacteria commonly colonizing this area are species of Lactobacilli and Corynebacteria and do not grow well under the laboratory conditions used to isolate the common urinary tract pathogens.

Another source of error may result from relying on the presence of WBCs. Many authors suggest that more than five WBCs per high power field is suggestive of a UTI. The presence of pyuria, however, is dependent on many different factors: How much fecal or vaginal contamination took place in obtaining the sample; the degree of hydration at the time of collection; the degree of inflammation in the urinary tract; the volume, time and speed of centrifugation of the urine; and the volume in which the supernatant is suspended. Other diseases of the urinary tract such as tuberculosis, glomerulonephritis, stones or a bacterial urethritis can elicit a leukocyte response in the urine. Thus, the number of WBCs in the urine is a poor criterion for estimating bacteriuria. In summary, the urinalysis should be used as an adjunct to the diagnosis of a UTI, but not in lieu of the urine culture.

Bacteriology

Most urinary tract infections are caused by the gram-negative aerobic bacilli commonly found in the gastrointestinal tract. If the urine sample has been collected properly, a positive urine culture should contain only one organism. Over 80% of uncomplicated UTIs are due to *E. coli*. Other gram-negative organisms found in UTIs are Klebsiella, Proteus and Enterobacter. Fewer than 5% of uncomplicated UTIs are caused by Pseudomonas, Staphylococci and group D Steptococci. Diphtheroids, *Staphylococcus epidermidis* and microaerophilic streptococci are highly suspect contaminants. In addition, any one of the following conditions will reduce the colony count: antimicrobial therapy, hydration, frequent voiding, fastidious organisms and the presence of cleansing detergent in the culture bottle.

The best urine for culture is the first voided specimen in the morning. The urine should be held no longer than one hour at room temperature. It may be refrigerated for up to 48 hours without significant alteration of the colony count.

Management of UTI

The management of a child with urinary tract infections can be divided into three categories: A. Treatment of the acute infection, B. Visualization and correction of significant anatomic abnormalities of the urinary tract, and C. Prevention of further infectious episodes.

A. *Treatment of Bacteriuria*

In the uncomplicated UTI the most common pathogen is *E. coli*. These bacteria are generally sensitive to a wide variety of antimicrobial agents: sulfonamides, ampicillin, nalidixic acid, nitrofurantoin, tetracyclines, cephalexin, and even to high concentrations of penicillin G.

Therapy with one of the above drugs should be given for a period of two weeks. There is little evidence to support a longer period of therapy except in those patients who relapse with the same organisms. With any of the above drugs prompt response is expected. The urine culture should be sterile within 48 to 72 hours. This point should be remembered, as prolonged therapy with an ineffective drug not only costs money but also time.

In our clinic we generally begin therapy with sulfisoxazole (Gantrisin) because it is effective, inexpen-

TABLE 4

Suggested Antibiotic Therapy for UTI in Infants and Children with Normal Renal Function

	THERAPEUTIC DOSAGE	COMMON SIDE EFFECTS	COMMENTS
I. NEWBORN			
1. Ampicillin	100 mg/kg/day I.V. in 3-4 divided doses x 7-10 days	Phlebitis at I.V. site Eosinophilia Maculopapular rash Fever	
2. Kanamycin	15 mg/kg/day I.M. in 2 divided doses x 7-10 days	VIIIth damage Fever, rash, eosinophilia Sterile abscesses at I.M. injection sites	Systemic use of kanamycin and gentamicin should be restricted to the treatment of serious infections by susceptible gram-negative bacteria
3. Gentamicin	5 mg/kg/day I.M. or I.V. in 2 divided doses (↑ to 7.5 mg/kg/day I.M. or I.V. in 3 divided doses x 7-10 days after 2 wks of age)		
II. OLDER INFANTS AND CHILDREN			
A. Acute UTI			
1. Sulfisoxazole	120-150 mg/kg/day p.o. in 3-4 divided doses x 2 wks	G.I. disturbance, rash, pruritis, fever or malaise	a) Contraindicated in 1. sulfa allergy 2. G6PD deficiency 3. infants < 2 months old b) Maintain adequate fluid intake
2. Ampicillin	100 mg/kg/day p.o. in 3-4 divided doses x 2 wks	G. I. disturbance Maculopapular rash Fever Eosinophilia	a) Contraindicated in penicillin allergy
3. Nitrofurantoin	5-7 mg/kg/day in 4 divided doses x 2 wks	Nausea/vomiting Peripheral neuropathy	a) Contraindicated in infants < 1 month b) Nausea may be minimized if given with meals
B. Chronic Recurrent UTI			
1. According to culture and sensitivity testing			
C. Suppressive			
1. Nitrofurantoin	As above x 2 wks After 10-14 days dosage should be reduced to 1/2. After a total of 4 wks of therapy, dosage should be reduced to 1/4.	As above	
2. Methenamine salt (Mandelamine)	< 6 y/o 50 mg/kg/day in 3 divided doses		
	6-12 y/o 500 mg p.o. q.i.d. in divided doses	G.I. disturbances Rash Hemorrhagic cystitis	a) Maintain urine pH etc. with ascorbic acid

sive and generally well tolerated (Table 4). Sulfa should be avoided in patients who are allergic to the drug or who have a glucose 6-PD deficiency. The second drug which we use is ampicillin. This drug is also effective and safe but has the disadvantage of causing diarrhea in some patients. It is also more expensive than sulfisoxazole. Nitrofurantoin is our third drug. It, likewise, is effective and inexpensive. Its major drawback is the production of nausea and vomiting in some 10-15% of cases. A real advantage to nitrofurantoin is that most enteric bacteria remain sensitive to the drug even after prolonged use. It is an excellent drug for long-term suppressive therapy. Tetracyclines are effective against enteric bacteria but are not recommended in this clinic for any child under the age of eight because of the drug's effect on de-

veloping teeth and growing bones. All the other antibiotics are considered secondline drugs. They are used only in those situations when the isolated bacterium is resistant to the drugs mentioned above.

Urinary tract infections in the newborn period should be considered part of a generalized gram-negative sepsis, as the bacteria are generally isolated from both blood and urine. In this situation a drug is needed which will produce bactericidal levels in the blood and urine and which has a broad spectrum. We begin therapy with either ampicillin, gentamicin or kanamycin.

B. *Indications for Visualization of the Urinary Tract*

Any spontaneous infection in a male should be followed by a radiologic evaluation of his urinary tract. The initial studies should include: (a) an intravenous pyelogram (IVP) for adequate visualization of kidney size, calyces, pelvis and ureters; (b) a voiding cystourethrogram (VCUG) to determine bladder size and shape, the presence of ureterovesical reflux and to visualize the bladder outlet as well as the urethra. If these two studies are normal, no further evaluation is necessary. Urologic consultation should be sought if these studies reveal an obstructive lesion, a diverticulum or significant (grade 3) ureterovesical reflux without obvious obstruction (Table 5).

At the present time there is a controversy as to when a young female with a well-documented UTI should be evaluated. The present available data suggest that 80% of young girls with one UTI will have another. In most instances these recurrences are not relapses but true reinfections with a different bacterium. A significant portion of these recurrent infections will be asymptomatic. Thus, many nephrologists are recommending radiologic evaluation following the first infection. In this clinic we recommend evaluation after the first infection in all those girls in whom we feel close follow-up will be difficult, in whom the initial episode was clinically severe, or in whom there is evidence of renal functional impairment. The initial studies should include an IVP and a voiding cystourethrogram.

The IVP can be performed at any time following the diagnosis of a UTI. The VCUG is usually postponed for several weeks following the infection to allow the bladder time to recover from acute inflammatory changes. Almost all VCUG will reveal ureterovesical reflux if obtained at the time of the acute infection. Ureterovesical reflux is a common finding in females with symptomatic UTIs. Reflux also has a tendency to disappear spontaneously with age. If reflux is noted and is associated with hydroureter, hydronephrosis and/or retarded kidney development, serious consideration should be given to a ureteral reimplantation procedure. Those patients with mild or moderate reflux (Table 5), without evidence of hydroureter, hydronephrosis or kidney damage can be managed medically.

C. *Prevention and Detection of Recurrent UTI*

It is imperative that the physician caring for children with UTIs recognize that although these infections occur as isolated episodes, recurrence is common and often completely asymptomatic. Over 70% of recurrences will come within a year of the initial episode. Factors contributing to infections of the urinary tract include neurological abnormalities, obstructive malformations or any condition which allows residual urine to remain in the urinary tract after voiding. Any of these conditions can be detected by the radiologic procedures previously described. The majority of children with UTIs have no demonstrable anatomic abnormality. Optimal medical therapy in these children should be early detection of reinfection and vigorous antibiotic therapy of all UTIs.

All patients with a UTI should be treated with the appropriate antibiotic for two weeks. One week following therapy the urine should be recultured to be sure the infection has been eradicated. Even in the absence of overt infection, the urine should be recultured monthly for 3 months, then bimonthly for the next 6 months and at three-month intervals for the next 15 months. If the patient has no recurrences in two years he/she can probably be considered cured.

In those patients in whom UTIs recur, continuous antimicrobial therapy should be considered. This therapy is generally instituted with either nitrofurantoin or methenamine salts after the second or third infection. Nitrofurantoin is instituted in full therapeutic dosage. After two weeks of therapy the dosage can be reduced to minimize side effects (Table 4). If a recurrence develops on low dose suppressive therapy, another drug should be considered. Methenamine salts are not effective agents in treating an established UTI and should be used for suppressive purposes only. To be effective in this latter regard, the urine pH must be less than 6.0. This is usually accomplished by adding ascorbic acid. Suppressive therapy should be continued for six months in patients without demonstrable urinary tract abnormalities

TABLE 5

Grades of Ureterovesical Reflux

Grade 1 or **mild**	reflux into the lower ureter only
Grade 2 or **moderate**	reflux extends to the kidney without abnormal dilation of ureter or calyces during micturition
Grade 3 or **gross**	reflux up to the kidney with pronounced dilation of the calyces

and for up to two years in those patients who have reflux. While on suppressive therapy, the urine should be recultured as described previously. The reader is reminded that, in patients with renal functional impairment, modification of the usual dose of certain antibiotics is necessary. Most children with recurrent UTIs have normal renal function, so dosage adjustments are generally not a problem. Kunin has written extensively concerning this aspect of antibiotic therapy.

Children with demonstrable radiographic abnormalities and recurrent infections should have yearly IVPs to detect progression of kidney damage. Children with significant abnormalities who are on medical therapy should have serial IVPs every 6 to 12 months until their lesion stabilizes or is corrected. Repeat VCUGs are not necessary if the IVP is normal or reveals no progression of upper tract disease.

In summary, urinary tract infections are common in childhood. They are often recurrent, asymptomatic and associated with nonspecific symptoms. The diagnosis of a UTI must be established by urine culture. Radiologic visualization of the urinary tract should be performed in all males with a UTI and in those females with recurrent UTIs. Ureterovesical junction reflux occurs in about 30% of children with UTI, while major urinary tract anomalies occur in about 8%. The relationship between recurrent UTI and chronic pyelonephritis is not clearly understood. Thus the onus is on the physician to properly establish the diagnosis, to treat the infection with adequate antibiotic therapy, to visualize radiographically the urinary tract and to periodically monitor the urine so that recurrent UTIs are kept at a minimum.

SUGGESTED READING LIST

General References

1. Stamey, T.A.: *Urinary Infections,* The Williams and Wilkins Co. Baltimore, 1972.
2. Kunin, C.M.: *Detection, Prevention and Management of Urinary Tract Infections.* Lea and Febiger, Philadelphia, 1972.
3. Smallpiece, V.: *Urinary tract infection in childhood and its relevance to disease in adult life.* The C.V. Mosby Co., Saint Louis, 1969.

Infections in Newborns

4. Littlewood, J.M.: 66 infants with urinary tract infection in first month of life. *Arch. Dis. Child,* 47:218, 1972.
5. Edelmann, C.M., Jr., Ogwo, J.E., Fine, B.P., et al.: The prevalence of bacteriuria in full-term and premature newborn infants. *J. Pediatr.* 82:125, 1973.
6. Bergstrom, T., Larson, H., Lincoln, K., et al.: Studies of urinary tract infections in infancy and childhood. XII Eighty consecutive patients with neonatal infection. *J. Pediatr.* 80: 858, 1972.

Infections in Infants and Children

7. Cohen, M.: Urinary tract infections in children. I. Females aged 2 through 14, first two infections. *Pediatrics* 50:271, 1972.
8. Wein, A.J., Schoenberg, H.W.: A review of 402 girls with recurrent urinary tract infection. *J. Urol.* 107: 329, 1972.
9. Forbes, P.A., Drummond, K.N. and Nogrady, M.B.: Initial urinary tract infections. *J. Pediatr.* 75:187, 1969.
10. Dolan, T.F., Jr., Meyers, A.: A survey of office management of urinary tract infections in childhood. *Pediatrics* 52:21, 1973.

Radiology in Urinary Tract Infections

11. Altman, D.H., Greenberg, L.A., Litt, R.E., et al.: Urinary tract infections in children. *Semin. Roentgenol.* 6: 259, 1971.
12. Kelalis, P.P., Burke, E.C., Stickler, G.B., et al.: Urinary vaginal reflux in children. *Pediatrics* 51:941, 1973.

Urology of Urinary Tract Infections

13. Walker, D., Richard, G.A.: Urethral obstruction in girls. *Pediatrics* 51: 272, 1973.
14. Kendall, A.R., Karafin, L.: Urinary tract infection in children: Fact and Fantasy. *J. Urol.* 107:1068, 1972.
15. Stephens, F.D.: Urologic aspects of recurrent urinary tract infection in children. *J. Pediatrics* 80:725, 1972.

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Hoosiers Abroad—Report of a Case of Lassa Fever

JOHN L. HAMER, M.D.
Fort Wayne

LASSA Fever is now accepted as a very virulent and contagious viral disease, as first reported by Drs. John D. Frame, John M. Baldwin, Jr., David Gocke, and Jeanette M. Troup. Three of the first five people to have Lassa Fever died within 10 days of the start of the illness. As the primary physician of the first known case (L.W.) of Lassa Fever, I would like to present a brief historical resumé of this patient. The original report prepared by me one week after my return to Lassa, following L.W.'s death in Jos, was submitted to my home mission board medical director and made available to Dr. Frame and his group for use in preparing their article. This history of L.W. is largely as recorded in that publication.[1]

The illness seemed rather vague and benign at first, but all of a sudden L.W. became critically ill and went into shock. No cultures or blood chemistries were available in Lassa. So I arranged to transfer the patient to Bingham Memorial Rest Home in Jos, a facility 500 miles by road from Lassa, where laboratory and more complete hospital facilities were available. My reasons for making this decision were as follows:

1. The patient was showing signs of renal failure and loss of normal mental composure; she would need constant nursing care which was not available in Lassa.
2. Blood chemistry studies and serum electrolytes were not available in Lassa and would be needed.
3. The patient had a leukopenia and her condition was undergoing deterioration on Friday and Saturday, in spite of antibiotic therapy; viral studies should be done. The viral blood studies could not be done in Lassa, but if there were a deep freeze in Jos, specimens could be obtained and stored.

Arrangements were made by radio on Friday evening for the trip with L.W. to Jos from Lassa and Mubi. The flight on which L.W. went into Jos was a combined flight on which a dentist (Dr. Raymond Stayer) was arriving in Mubi to come to Lassa for his annual visit to our mission to treat people needing dental care; he gave his seat to our emergency party. Mrs. Hamer, a registered nurse, was already planning to take L.W. into Jos, but with L.W.'s deteriorating condition, both Mrs. Hamer and I went along in the small three-seated plane. A big supply of oxygen was not available at Lassa, but a small tank (less than half full) was available and was taken along on the 50-mile Land Rover trip to Mubi and into Jos on the plane. On the way into Jos, the small tank of oxygen was shepherded every bit as closely as the Apollo 13 Moon Flight's oxygen, and it was given only for signs of cyanosis or rapid pulse. The pilot and L.W. sat in front while Mrs. Hamer and I sat in the single back seat.

After L.W. was digitalized on her arrival in Jos, L.W. seemed improved for a while until she convulsed and again her condition seemed worse. However, she seemed better on Sunday morning. She heard a group of Sunday worshippers at the hospital singing songs in English and she recognized that it was English and not Margi language or Hausa language. By Sunday afternoon she appeared to be losing ground, both with physical signs and with clouding of her sensorium. Urine output was almost nil and L.W. died following a convulsion about 9:00 p.m. Sunday night.

When it was apparent an autopsy would not be done in Jos, the necessary blood was taken for both bacterial and viral blood studies by Drs. Hamer and Troup. This proved to be of great importance in identifying the cause of death of L.W. and tying together etiologically her death with that of the medical personnel who became sick and died subsequently.

Early the next morning my wife and I accompanied the body by small private airplane to Biu and then by Land Rover to Garkida, where Dr. McCann performed an autopsy.

The gross autopsy report was as noted in the article.[1] In addition, representative specimens were sent to the U.S.A. for histopathological study. The specimens may have become dried in the overseas air mail flight. The diagnosis made by the pathologist, Wayne Scott, M.D., was "severe lower nephron nephrosis, probably secondary to gastrointestinal hemorrhage." These specimens were sent to New York for further evaluation, but were lost in handling.

It wasn't until 7-10 days after the

Dr. and Mrs. Hamer are veterans of some 16 years of mission work (1953-1969) with the Church of the Brethren Mission in Nigeria, West Africa.

death of L.W. that a request was received from Dr. Jeanette in Jos asking for the results of the autopsy findings on L.W. This raised the suspicion that someone else might be sick with a similar disease. Then, a letter from our daughters in boarding school in Jos confirmed that one of the nurses (C.S.) who had been caring for L.W. was very sick and might die. My wife had also cared for L.W. in Jos as well as in Lassa; our anxiety grew more intense.

Later, when another (L.P.) also came down with a similar illness, Mrs. Hamer (who remained well) and I were convinced that L.W. had died from a highly virulent infectious disease. We had been correct when we suspected an unusual virus disease and transported our patient to Jos. This impression was confirmed in May 1969 by Dr. John Frame in a letter to our mission.

REFERENCES

1. Frame, J.; Baldwin, J. Jr.; Gocke, D. and Troup, J.: Lassa Fever, A New Virus Disease From West Africa, *The American Journal of Tropical Medicine,* July 1970, Vol. 19, No. 4.
2. Beeson and McDermot, editors, *Internal Medicine* (Cecil and Loeb), W. B. Saunders Co., Philadelphia, 1971, pp. 459-460. ◄

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About Our Cover

Once again The Journal is indebted to Dr. Wei-Ping Loh, Gary pathologist and member of our Editorial Board, for a delightful work of art for our July cover. The painting commemorates The Year of the Tiger, the 4,672nd year of the Ancient Chinese calendar. A different "Tiger" painting by Dr. Loh recently appeared on the cover of the Journal of the American Medical Association.

Dr. Loh is the chief pathologist for the Gary Methodist Hospital and the Lake County Coroners Office. He also has the rank of Full Clinical Professor at the Chicago Medical School. He is presently serving as president of the American Chinese Medical Society, headquartered in New York City, and as vice president of both the American Center for Chinese Medicine in Washington, D.C., and the American College of Acupuncture and Chinese Medicine in San Francisco.

Cancer Symposium for the Primary Care Physician

When: September 12/13, 1974

Where: Inn Of The Four Winds, Smithville

What: Golfing, tennis, sailing, skiing, swimming, fishing, hiking, superb dining **and** a cancer seminar for the practicing physician. Emphasis of the program will be on practical aspects of diagnosis and treatment of cancer. The two-day program will be jointly sponsored by the Indiana Division of ACS and the Department of Medical Education, Methodist Hospital, Graduate Medical Center, Indianapolis.

Seminar meetings will convene Thursday and Friday. Registrant's accommodations will be available after 2 p.m. on Wednesday. Ample time is being scheduled into the program for enjoyment of the recreation and beauty of the environment.

Topics and speakers include:

Hodgkin's Disease and Non-Hodgkin's Lymphoma; Malignant Testicular Tumors—Recent Advances in Chemotherapy—Lawrence H. Einhorn, M.D.

Cutaneous Clues to Visceral Cancer; Indications and Contraindications for Topical Chemotherapy of Skin Lesions—William B. Moores, M.D.

Treatment of Multiple Myeloma —Laurence H. Bates, M.D.

Advances in Radioisotope Scanning—Eugene D. VanHove, M.D.

Which X-ray Equipment for Which Cancer?—John F. Dillon, M.D.

Malignant Trophoblastic Disease —Clarence Ehrlich, M.D.

Hypercalcemia and Inappropriate ADH—Roger Robison, M.D.

Neurosurgery Relief of Pain—Julius M. Goodman, M.D.

Malignant Pleural Effusion and Ascites—James E. Schroeder, M.D.

Infectious Complications of Neoplastic Disease—Donald Weiser, M.D.

Cancer Patient Rehabilitation—Donna Minnick.

CANCER CORNER

New information from
Indiana Division
American Cancer Society, Inc.
2702 East 55th Place
Indianapolis 46220

For a program brochure and registration cards for the seminar and accommodations, clip and mail the coupon to—

Department of Medical Education, Methodist Hospital Graduate Medical Center, 1604 North Capitol Ave., Indianapolis 46202

Attention: Dr. Wm. M. Dugan, Jr., Conference Chairman

LETTER

To All Physicians in Indiana:

We are currently interested in obtaining patients with disseminated testicular tumors for an ongoing investigational protocol which we are running in conjunction with M.D. Anderson Hospital and Tumor Institute in Houston, Texas.

This consists of combination chemotherapy using Adriamycin, which is an investigational antitumor antibiotic, in combination with Bleomycin and Oncovin. Our preliminary results with this combination have been excellent and we are quite interested in extending our patient population.

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1100 West Michigan St.
Indianapolis 46202
Telephone: 317-264-8229

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Particularly for you, doctor, our KEY volunteer. Your thinking, experience and guidance are responsible for the formulation of our policies and programs; your knowledge and skills are essential to their execution. So you serve on our National, Division and Unit boards. Act on our committees. Talk to lay audiences at our film showings. Help evaluate our research grants. Advise on our professional publications. Raise funds. Assess our program materials. The list goes on and on.

The American Cancer Society keeps you busy, doctor. We depend upon you.

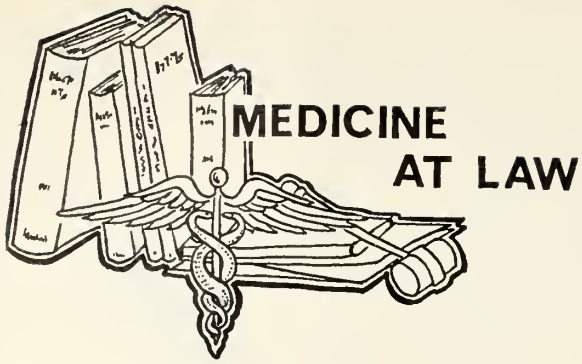
Please send program information and registration cards for the Cancer Symposium to:

Name: _____

Address: _____

City: _____

Zip: _____



Surgical Removal of Bullet Unreasonable Search—Surgical removal of a bullet from the buttocks of a man who was a suspect in an armed robbery was an unreasonable search, the Indiana Supreme Court ruled.

Three armed men robbed a supermarket at closing time. During a gunfight with police officers at the scene, one robber and one policeman were killed and one robber was wounded. Several weeks later a suspect in the robbery was arrested on a charge of disorderly conduct. At the police station the police officers noticed two recent bullet wounds on his hips and buttocks. X-ray revealed that metallic fragments were still present in the flesh.

An affidavit on an informer's statement that the man was one of the robbers was filed to obtain a search warrant to retrieve the metal fragments. The court authorized the removal of the fragments. Using a local anesthetic, a physician removed the bullet fragments from the suspect's body. Based on that evidence the suspect was convicted of premeditated murder and felony murder, and he appealed.

On appeal, the Indiana Supreme Court discussed the issue of the reasonableness of the court-ordered operation on the suspect to secure evidence to establish his guilt or innocence. The Fourth Amendment, which provides for freedom from unreasonable searches, applied in this case, the court said. Further, holdings of the U.S. Supreme Court supported the court's view. Noting the Supreme Court's holding that a forced stomach pumping to obtain swallowed narcotic capsules was an unreasonable search, the Indiana Supreme Court said that limited intrusions upon the body of a suspect were reasonable. However, an operation to remove a bullet was not such a limited intrusion, the court said, and the man's conviction must be reversed.

In a concurring opinion, one justice would have reversed the conviction on the ground that there was no probable cause for the search warrant to be issued. The affidavit requesting the authorization to remove the bullet was deficient in its statement of facts known by the informant who connected the suspect with the case.

Two justices dissented, saying that the type of operation involved under a local anesthetic was relatively minor and was a reasonable search. Each case should be decided on its own circumstances, they said. —*Adams v. State of Indiana,* 299 N.E.2d 834 (Ind.Sup.Ct., Aug. 10, 1973).

Fall in Physician's Parking Lot not Compensable—A patient's fall in the parking lot of a physician who was treating him for a work-connected injury was not an accident related to his employment, an Indiana appellate court ruled.

The employee, a truck driver, was drawing temporary disability benefits under the Workmen's Compensation Act because of a leg injury. He was also receiving medical care that was paid for by his employer.

Because he was not satisfied with the physician who was treating him, the employee consulted a specialist, who performed surgery. The specialist's services were also paid for by the employer.

When the employee arrived at the specialist's office for a follow-up appointment, his crutches slipped on ice in the parking lot. He fell, allegedly sustaining an arm injury.

The employee filed an application for workmen's compensation for the injuries sustained in the fall. The Industrial Board denied the application, and the employee appealed to the court.

As a matter of law, the court said, the record did not lead solely to the conclusion that the employee was performing the duties of his employment at the time of his injury. Therefore, the court affirmed the decision of the Industrial Board—*Smith v. National Liquors, Inc.,* 301 N.E.2d 783(Ind.Ct. of App., Oct. 17, 1973).

Treasurer's Name Omitted

In the listing of the Indiana Philippine Medical Association in the Yearbook (p. 419, June issue), the name of its treasurer was unintentionally omitted. He is Jaime A. Salomon, 1917 Brewster Road, Indianapolis 46260.

The Journal
of the INDIANA STATE MEDICAL ASSOCIATION

Devoted to the interests of the medical profession of Indiana

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Druggists Extol Use of Patient Profile Records

THE Indiana Pharmaceutical Association reported recently in *The Indiana Pharmacist* about a survey of its members and their use of patient medication records.

Answers were received from 503 members. Active use of the patient medication record was reported by 71%.

Those who are using the record are enthusiastic about its advantages. Quotations from the questionnaires tell of the discovery of patients with prescriptions for drugs to which they are allergic. Frequently patients are taking prescription drugs from two or more doctors at the same time. The pharmacists report several instances of incompatibility or dangerous combinations.

By referring to the record of patients' ailments, some of the druggists were able to counsel customers as to the inadvisability of purchasing over-the-counter preparations which would have been deleterious.

Customers are aware of the system and are appreciative. A chain store closed its only store that kept records and moved the patient information to another of its stores three miles away and past two other drug stores. Ninety percent of the prescription customers of the closed store followed their medication records.

One pharmacist kept his patient profile records by families until he found that the practicality of the system was great enough to warrant an individual card for each person.

One respondent summed it up by "Our whole prescription system of filing is based on profiles. We have used profiles for eight years, it has served us well."

Ignorance on Health Matters Widespread

IN spite of the great mass of health information which is available to the public, it has been discovered that the American public is badly informed on health matters.

A recent survey which was conducted by the FDA found "a surprising degree of ignorance on health matters among all economic and social levels."

The findings were:

1. Americans prefer to diagnose their own ills, rather than go to a doctor. They also tend to believe the experience of friends or relatives over the advice of doctors or scientists.

2. They believe that "good health" means being "super healthy," without recognizing that some fatigue, unhappiness and discomfort is normal.

3. They believe that "not eating right causes most illnesses, including cancer and arthritis." One in three believed in unsound weight-reduction methods.

4. They believe doctors concentrate too much on science, and say they are opposed to doctors employing "new and different ways" of treating disease.

The survey was made by using accepted opinion-sampling technics. It was on a national basis and covered all levels of society. The findings may be considered as reliable.

Practicing physicians will recognize many of the points of misinformation but will be surprised to find that they are so generally held and are characteristic of all economic classes.

The subject is discussed by Harold F. Osborne, assistant director of information in the National Institutes of Health, in *Medical Communications,* the official publication of the American Medical Writers Association.

Mr. Osborne, in viewing the problem as a medical writer, discusses the possibility that the dilemma is the result of faulty medical writing. The great volume of medical writing and the demonstrated popularity of it with the public would tend to lend credence to this theory. However, the high quality of articles by the science writers of today would make it seem that there must be some other deficiency in the system.

Editors of newspapers and magazines have found that there is no more popular material than the

health or medically oriented article. Why should the majority of the citizenry, who ostensibly read well written health stories all the time, flunk the practical test when it comes to their own personal beliefs about their own health?

Two things are evident—there is no easy explanation for the deficiency in practical health knowledge, and there is no doubt that it should be corrected.

Could it be that a national public information campaign, similar to the one now being mounted for the management of hypertension, be organized to educate the public on each of these specific "misinformations"?

Should the National Institutes of Health sponsor such a campaign? If so, the FDA should repeat the health information survey later to discover the result and to demonstrate further areas of misinformation.

Advice not Taken

ADVICE which should have been followed. The August 1951 issue of *The Journal* quotes in part an editorial which appeared in the *Bulletin of the St. Louis Medical Society,* under the title of CRUMBUMS. How much better the world would be today if the warning had been heeded and the proper action taken in 1951. The editorial makes good reading for today:

> The daily press is reporting with increasing frequency, the incidence of narcotic addiction among mere children. To find a name for a character so contemptible that he would peddle dope to kids we must turn to the lexicon of the kids. To them, the lowest form of human life is a "crumbum."
>
> * * * * *
>
> We quote a headline from a recent newspaper story: "Couple Gets Five Years for Dope Peddling." *Five years!* And they may be free in two, or two and a half, or three years. Free to go back to where they cached the $270,000 they made in six months selling heroin. What crum-bum—or for that matter, a higher order of bum—would not be willing to spend three or even five years in the pokey for that kind of money? The same edition stated that Al Capone's brother faced sixteen years for tax evasion; a writer of rubber checks was sentenced to six years in another story in the same edition. But for a couple who had murdered the souls and minds and futures of kids; who had helped rob them of the opportunity to grow into healthy, happy, ambitious citizens of a community where they could walk proudly with their fellows—five years.
>
> This is in no sense an indictment of the judge who pronounced sentence, for—again we quote—this was "the maximum time the court could impose." If five years constitute the maximum time that a judge is permitted to put away these termites of our social structure, then it is high time that the lawmakers re-examine relative values. If spies, saboteurs, and other traitors to our country can be given life sentences, then those who would sabotage the children upon whom the nation's future depends should be given life sentences. If a murderer can be given the electric chair, then those who would create thieves, murderers, and prostitutes deserve no less. Something drastic should be done to protect these kids!

Hoosier Editor Speaks on PSROs

THE Medical Association of Georgia held a meeting in early April to discuss PSRO. Dr. Harrison L. Rogers, Jr., of Atlanta, speaker of the MAG House of Delegates; Marvin "Mickey" Edwards, former editor of *Private Practice;* Dr. J. W. Johnson, president-elect of the San Diego County Medical Society; Dr. James H. Stewart, president of the Louisiana State Medical Society; Philip Crane, U.S. Representative in Congress from Illinois; Dr. L. C. Buchanan, vice speaker of the MAG House of Delegates, and M. Stanton Evans, senior editor of the *Indianapolis News,* addressed the assembled physicians. The remarks of Mr. Evans are reported in abstract form as follows:

Mr. Evans said there is no medical care crisis in this country, despite reports to the contrary.

Of the law, he said: "This is not a bill that gives you control over your own profession, but on the contrary . . . gives the Secretary of Health, Education, and Welfare complete control over what you do . . ." It also would destroy doctor-patient confidentiality and "is a formula for the bureaucratic takeover of the medical profession," he said.

Noting that the PSRO law came into being because spending for Medicare and Medicaid "is totally out of control," he said the problem the law addresses is one created by the federal government and its intervention into the medical care system.

Though original Medicare and Medicaid legislation contained assurances that government would not intervene in the provision of medical care, "now, of course, we see that in PSRO, that assurance was meaningless," he said. "It is a delusion and, indeed, an intellectual fraud upon the nation to suggest that you can have an extensive program of governmental subsidies without accompanying governmental controls."

Predicting that under any national health insurance program the PSRO-type control would be expanded, he said: "We are looking down the barrel, right now, in this controversy, of total bureaucratic control of your profession, and of all our lives."

He suggested that the answer to the overall program is to begin phasing out massive federal health care programs, and noted that a bill has been introduced in the Indiana legislature to repeal Medicaid in that state.

The "subsidy and control" sequence has increased the state cost of Medicaid in Indiana from an initial estimate of $300,000 per year to $115 million annually, Evans said.

Labeling arguments that repeal of PSRO is impossible as "obvious nonsense," Evans also attacked the idea that it is necessary for the medical profession to provide "input" for PSRO implementation. "The problem in America today is not the private practice of medicine . . . but is precisely government in-

tervention in our economy and in our lives," he said.

Praising Georgia's repeal effort, he urged MAG to enlist support of other segments of society and, in turn, to assist other interests plagued with increasing government intervention. "Don't presume that it is possible for your profession to remain free while the rest of society is becoming minutely regulated and controlled out of Washington—it simply isn't possible," he said.

Citing statistics on the growth in federal spending, he said it is "tremendously encouraging to see a profession such as your own . . . take the stand that you have taken here in Georgia." He added "The repeal of PSRO, while it must be attained, should be only the beginning in a fight to liberate our entire society from this network of government regulations that can strangle all our liberties."

Editorial Notes . . .

"If emotional pressure and tension do play a role in hypertension it would seem that the greatest pressure is at the lower end of the economic ladder." So announces the Health Institute in a recently released story. It has been found that families with incomes of $2,000 per year or less have a higher rate of high blood pressure than families with income over $10,000. Also, there is more hypertension among persons with less than five years of education than with persons with more than 13 years of education.

Peter Lassen, an architect who is confined to a wheelchair due to Vietnam-acquired paralysis of his legs, has written a book, *Barrier Free Design: A Selected Bibliography,* a collection of references to the literature of building for the handicapped. Lassen is an advisor to VA architects and engineers and serves as architectural coordinator for Paralyzed Veterans of America.

Survey of 75 Massachusetts hospitals showed that a high percentage of fires in hospitals are never reported. Also, that fire prevention programs are not as effective as believed and that the correction of such programs is not within the expertise of the hospital staff. Most hospital fires are due to smoking by employees either in unauthorized areas or without due care. Only a small percentage of fires are caused by patient negligence and these were usually due to smoking.

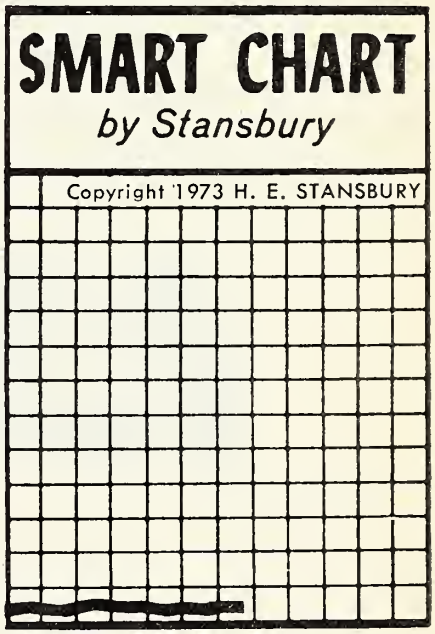
Posttransfusion hepatitis is either substantially reduced or completely eliminated by the technic of deep-freezing red cells. Leucocytes, which may carry viruses and which may contain antigens, are eliminated in the freezing, thawing and washing process. Plasma antigens and antibodies are also removed. Rare types of blood may be stored indefinitely. For these reasons it is now felt that the freezing process for preservation of blood, which carries a higher cost per unit, is not a luxury but a clinical necessity.

A bill in Congress would authorize the FDA to halt the sale of hazardous products. This was occasioned by the discovery that at present the FDA can only *request* voluntary recall of products such as vinyl chloride which, it is now known, may cause a form of liver cancer.

New York City prohibits the cruising of taxicabs in Midtown Manhattan between 8 a.m. and 7 p.m. six days a week. Cruising cabs account for 15% of the traffic. If enforced, the rule will decrease atmospheric CO by 3%.

Uranium mill tailings, the sand-like residue of milling uranium ore, the subject of special attention, are located in 22 locations in eight western states. The Atomic Energy Commission is requesting assistance from the states involved in surveying the tailings, which contain natural radium and produce radioactive radon gas. The size of the tailings ranges from two acres to more than 100 acres, and from about 100,000 tons to more than 2.5 million tons. Some of the tailings have been used in the past for construction of homes and public buildings. The 22 mills concerned are all inactive. Seventeen active mills are under contract to control tailings during operations and to stabilize the tailings when operations cease.

A new communications satellite will be used for medical communication. Ten VA hospitals, in conjunction with the Foundation for Applied Communications Technology, will test the system for consultations via television. The spacecraft is in a geosynchronous orbit, some 22,300 miles above the equator, and will match the earth's rotational period and remain in a fixed point in relation to the earth. The 10 VA hospitals are all in the Appalachian region where mountainous terrain makes other types of communication difficult. ◄



"We are in sound fiscal health, poised to capitalize on the forthcoming upturn."

Inner-city children are found to have higher blood-lead levels than children from outlying areas. Lead based paint pica is one possible source. Also, house dust in the inner city has been found to be higher in lead than it is elsewhere. Another point—as a general rule the residents of Los Angeles have higher blood-lead levels the closer they live to the freeway.

Gov. Otis Bowen spoke at the annual Doctors' Day banquet sponsored by the Jefferson County Medical Society at Birmingham, Ala., recently. He criticized bills now in Congress which "set up a public service-type commission to regulate all phases of the practice of medicine." He also said that PSRO "will be one of the most divisive programs ever created. It will pit doctor against doctor, doctor against hospital and doctor against reviewing clerks."

The recurring reference to the fact that physicians do not know as much about drugs as they would like to is getting a little tiresome. As a matter of fact, there is no part of clinical medicine—diagnosis, prevention, treatment or anything else—on which an honest doctor would claim to be fully informed. All of us, every day, realize that it would be nice to have greater knowledge. While all physicians desire more expertise on pharmaceuticals, it is probably the one part of clinical practice at which physicians are at their best, due to the fact that almost all doctors actually use no more than about 30 drugs. We don't know everything about every drug but busy practitioners can and do know about the drugs they use. The next time you see Senator Kennedy, tell him so.

Prostaglandin F_2 alpha, on clinical trial, is reported to have successfully and safely induced labor when given intravenously to 44 high-risk patients and 56 patients without complications. All women had undilated cervices at time of induction and completed vaginal delivery in the average time of 5.5 hours.

The shortage-oriented 55 m.p.h. speed limit gets more and more votes every day. Fatalities in Indiana up to April 21 of 1972, 1973 and 1974 have been 410, 449 and 268.

Drug information and promotion by mail has declined by 38% since 1959. Modern techniques make the mailing pieces more selective and more efficient. PMA President Joe Stetler notes that some direct mail is irritating to doctors but that the greater part of it is helpful and welcome. Fewer than 3,600 physicians annually request that their names be removed from mailing lists, a small percentage of a total of 320,000. Thirty-six percent of practicing physicians work in rural areas where detail men are scarce and postgraduate education is minimal—it is here that direct mail from pharmaceutical manufacturers is most helpful, especially that type which warns of newly discovered side effects and dangers.

A fatality, the first in Indiana, in a car equipped with an air bag has been investigated. The bag inflated properly and protected the adult driver from serious injury. However, the fatality involved a 7-week-old boy, who was lying unrestrained on the front seat and was rolled forward against the dashboard before the actual impact.

Dr. J. Richard Crout, director of the FDA Bureau of Drugs, recently at a Congressional hearing, stated that the FDA had no intention of interfering with the practice of medicine. At the same hearing he sought to reassure Senator Kennedy that overprescribing could be eliminated. He recommended that PSROs use the prescribing of certain drugs for the delivery of high-quality medical care. He also suggested "certification of physicians, limiting the use of certain kinds of drugs by certain kinds of physicians. He thought these same strategies could be used against the same doctors who are also misusing diagnostic procedures. ◄



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Professional Standards Review Legislation—Statement of ISMA Position

WILLIAM F. BLAISDELL, M.D.
Seymour

THE Indiana State Medical Association acting within the limits set by its governing body through resolution and reaffirmed by recent action of its Board of Trustees cannot cooperate in the implementation of Professional Standards Review legislation in Indiana.

The ISMA can find no other ethical position because of the infringement by the law on patient rights and traditional moral responsibility for judgment by the physician in the treatment of his patient. The ISMA is most concerned about the loss of confidentiality of patient records, the loss of the patient's right to benefit from individualization of his treatment and loss of access to hospital care as a result of PSRO provisions.

The ISMA also believes that Public Law 92-603 (Sec. 249F) does not truly provide for peer review and that it creates another expensive bureaucracy which duplicates existing utilization review and will interfere with the local peer review process.

The ISMA believes that the fundamental concept of the treatment of the patient rather than his disease is not recognized by Public Law 92-603 (Sec. 249F); similarly the vital aspect of Medicine that is art is ignored.

Summary of the principal points of the testimony of Dr. Blaisdell for the Indiana State Medical Association before the Subcommittee on Health of the Committee on Finance of the United States Senate, May 9, 1974.

Mr. Chairman and Members of the Subcommittee:

I am Dr. William F. Blaisdell of Seymour, Indiana. I have been designated by the Indiana State Medical Association to present to you the situation in Indiana regarding the implementation of the provisions of Public Law 92-603, the so-called PSRO law.

First, let me read to you a brief resolution from the Indiana State Medical Association House of Delegates meeting in the fall of 1973:

> RESOLVED, that the Indiana State Medical Association be permitted to establish an independent corporation to accomplish peer review and quality control. Such review to be conducted only if requested by the local reviewing body; and
>
> BE IT FURTHER RESOLVED that the Indiana State Medical Association urges the members of the House of Representatives and the Senate from the State of Indiana to repeal the PSRO provisions of Public Law 92-603.

On April 21, 1974, at Indianapolis, at a meeting of the Board of Trustees of the Indiana State Medical Association, a motion requesting approval for an ISMA-connected organization to accept federal funds for formation of a PSRO Support Center was disapproved.

At that same meeting, the Board of Trustees voted unanimously to reaffirm its position in opposition to the concepts of PSRO and in favor of repeal of Public Law 92-603. The Board of Trustees of the ISMA urged, by resolution, that the American Medical Association House of Delegates at its June 1974 meeting, reaffirm its opposition to Public Law 92-603 (Sec. 249F). Additionally, you should know that the 98th session of the Indiana General Assembly, as a result of members' awareness of PSRO legislation and with both houses voting unanimously, requested the U.S. Congress and the National Administration to re-evaluate current federal policy regarding provision of health care services and to take appropriate steps to eliminate unwarranted interference with the private practice of medicine. Further, the Indiana Academy of Family Practice at its recent annual meeting moved for repeal of PSRO. A majority of the members of the Indiana delegation to the U.S. House of Representatives now oppose this law.

Governor Otis Bowen of Indiana, himself a physician, in testimony before the Subcommittee on Public Health and Environment of the Interstate and Foreign Commerce Committee of the House of Representatives, states:

> My concern is that the freedoms and ingenuities of our physicians not be shackled and that the quality of care for our citizens not be jeopardized by well-intentioned yet unworkable legislative and bureaucratic requirements.
>
> Full and complete consideration must be given to the fact that the basic element to all medical practice is the patient and care should be "Standardized" in only the broadest sense.

What is the impact of the Indiana State Medical Association position relative to the implementation of

the provisions of the PSRO law in Indiana? The Indiana State Medical Association cannot, in good conscience, with the best interests of the medical patients of Indiana and with exercise of the highest principles of medical ethics, participate in the implementation of the Professional Standards Review Organization provisions. The Indiana State Medical Association has taken no action to influence individual physicians or other groups of physicians in the exercise of their judgment regarding the issue of PSRO, except through the promulgating of factual information as regards provisions of the law.

The ISMA believes that an explanation of our position based on a few principal points is in order. At the outset, let us clearly enunciate the concept that we see in the PSRO law no political or financial issues which in any way substantially affect the practicing physician, although we object in principle to the areas of punitive payment of benefits and fines provided in the law. (Reference Public Law 92-603 (Sec. 249F), section 1159 (a) (b) and section 1160 b (1) (2) (3).) Our deep concerns about this law are based primarily upon the effects that the patient will suffer. The law establishes norms of care, diagnosis, and treatment of "particular illnesses and health conditions" (Section 1156 (B). The law fails to recognize that the discipline of Medicine requires the treatment of the patient not the disease—thus the establishment of norms must, by necessity, limit full individualization of care, diagnosis and treatment.

Appendicitis . . . Many Times Not

It may seem surprising to proponents of this legislation that a diagnosis as common as appendicitis is highly individual. It is individualized by age and sex; characterized by the presence, but oftentimes the absence of fever; sometimes the loss of appetite, many times not; sometimes vomiting, many times not; sometimes constipation, sometimes diarrhea, sometimes neither; and usually pain, but often not; and pain, if present, may not be in the usual area of the location of the appendix. Laboratory studies vary from a normal white blood cell count to a depressed or elevated white blood cell count. The urinalysis may vary from a normal to an abnormal urinalysis directly related to the presence of appendicitis. Finally, the x-ray findings demonstrating evidence of so-called ileus or bowel paralysis in the area of an inflamed appendix are sometimes present but oftentimes absent, and, when present, are by no means limited to the diagnosis of appendicitis.

Additionally, the attempt to quantify through establishment of norms of care, diagnosis and treatment will severely limit medical innovation. Medical progress has often come through innovation that was out of keeping with the 'norms' of the time in history at which they occurred; how could the contributions of Semmelweiss, Pasteur, Salk and countless others have been made under PSRO?

This law provides for "examination of pertinent records of any practitioner or provider of health care, etc." We believe the traditional confidentiality of medical records will be jeopardized with the result that important historical information will be withheld from the physician by the patient. Recent revelations regarding the loss of confidentiality at very high levels within the government give us no reassurance that the privacy of medical information is likely to be well safeguarded, despite a provision in the law that attempts to provide a mechanism for protecting such information.

We believe no one will argue that cost control is one of the major purposes, if not the major purpose of this act. If cost reduction is to be accomplished, it is obvious that it will have to be largely through decreased utilization because of the inescapable fixed costs in the health system. The inevitable result will likely be that availability of certain high cost treatment will probably be withheld. ISMA concurs with the concept that the U.S. government or any other entity has the right to inquire as to the cost and quality of a service or of goods it buys. That entity has the traditional right to accept or decline such services or such purchase. However, in the case of medical care, the government alleges to act as an insurer when, in fact, it acts as a purchaser under the provisions of the PSRO law and especially in the area of pre-hospital admission certification.

It should be the patient who has the right to inquire as to quality and necessity of use of a service for his health care. Who can know better than a patient in conference with his physician what his health needs really are? I can assure you that very, very few patients are willing to accept hospitalization without a real perceived need on their part. The patient, through the hospital preadmission certification provisions of Public Law 92-603, is preempted involuntarily by the law in the making of a crucial decision with his physician as to whether hospitalization is in his best interests.

Objections Outlined

The Indiana State Medical Association does oppose PSRO from the physicians' standpoint as well as the standpoints noted above. The principal areas of objections will be outlined briefly. Let me quote from the Hippocratic Oath, "The regimen I adopt shall be for the benefit of my patients according to my ability and judgement . . ." One must realistically wonder when a physician under the provisions of PSRO is confronted with a judgment that does not fall within the norms of care, diagnosis or treatment, how many physicians can realistically exercise their judgment for the patient's wellbeing when the physician must be confronted with the possibility of fine, other severe sanctions, and the loss of protection from civil liability when failing to conform to "norms," as established

as a result of this law. Many have argued this law provides a formalized peer review mechanism to be used in the United States in place of a so-called hit-and-miss system, which some would hold has been inadequate. We submit that this law is not peer review. In fact, that terminology is not used in the law. We note that the reviews are by bureaucratically approved and designated groups which are approved only so long as they perform in a manner acceptable to the Secretary of Health, Education, and Welfare who is himself the final authority in all matters of dispute. This law impugns the very qualities for which physicians are chosen and which are emphasized in their training—qualities such as decisiveness, inquisitiveness, confidence, self reliance, integrity and a sense of moral and ethical purpose.

Also, the provisions of this law propose a system which duplicates already existing utilization review activities in United States hospitals.

Public Law 92-603 (Sec. 249F) will interfere with true peer review by substitution of an unwieldy and impersonal approach in the place of true peer review programs. Truly useful peer review can only succeed at the local hospital and medical society level where professionals are judged by actual peers in an atmosphere of respect and dignity. In this setting deficiencies can be explored and corrected. The physician in question can be helped to continue to contribute to the total health care of the nation to the maximum extent possible.

The costs of the operation and administration of this system of Professional Standards Review will be enormous financially as well as ethically and medically. Estimates range from about $86 million annually to more than $500 million annually and the truth probably lies nearer to the upper figure. Savings to be realized financially by the taxpaying public and by the patient are almost certainly overall to be less than the cost of operating the system.

From the foregoing many standpoints and most especially from that of the loss of freedoms by our patients, we of the Indiana State Medical Association oppose the concept of PSRO and we cannot aid in its implementation in the state of Indiana. Finally, we suggest that Medicine is a science and that in the United States it is a science of the highest order. Medicine is also an art. Perhaps the crucial fault of the PSRO legislation is the failure to recognize the very considerable and vitally necessary part of Medicine that is art. Under PSRO Medicine will cease to be an art of the highest order. ◄

1124 Medical Place
Seymour 47274

Pediatricians are needed on the consulting staff of the Indiana Disability Determination Unit to help evaluate claims for disability benefits by children from families with limited income, under the new federal supplemental security income program. All physicians are welcome to apply as consultants for Social Security Disability Determination and perform the examinations in their office at an arranged appointed time for a fee. Physician openings are also available in the agency for full or part time work. There is no direct patient confrontation. Write or call the Disability Determination Division, 932 Illinois Building, 17 West Market St., Indianapolis 46204; Phone: 317-633-4533.

County Society Officers Conference

Approximately 120 officers of county medical societies, ISMA officials and members of the Woman's Auxiliary attended the County Society Officers Conference May 16 at the Airport Hilton Inn, Indianapolis.



JOE DUKES, M.D., Dugger, president, ISMA, addresses the County Society Officers Conference.



WILLIAM BLAISDELL, M.D. (left) Seymour, alternate trustee, chats with friends during break.



WILLIAM R. CLARK, M.D., Fort Wayne, member of ISMA Executive Committee, and Martin O'Neill, M.D., Valparaiso, alternate trustee.



FRANKLIN BRYAN, M.D., Fort Wayne; Mrs. Otis R. Bowen, wife of Governor Bowen, and G. Beach Gattman, M.D., Elkhart, trustee.



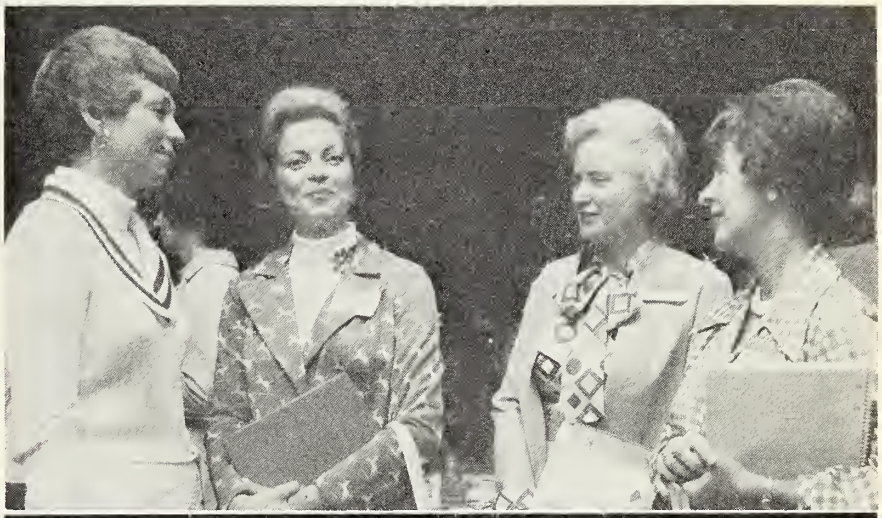
PART of the interesting program was the fable of "The Fox and the Chicken Coop," told by an actor in costume and imparting a message of what greed did to the roosters who accepted the Eastern foxes' offer for guarding bigger and better chicken coops on a national basis.



GILBERT M. WILHELMUS, M.D., president-elect, ISMA (left); Bernard Rosenblatt, M.D., trustee, and C. C. Young, Jr., M.D., all of Evansville.

AUXILIARY representatives came prepared to work (below).

WILLIAM R. CLARK, M.D., Fort Wayne, member Executive Committee; Glen Ward Lee, M.D., Richmond, alternate trustee; Mrs. Lee and Mrs. Clark (left to right far below).





PATHOLOGISTS GET TOGETHER. Trustee James A. Harshman, M.D., Kokomo (left), confers with Richard E. Palmer, M.D., Alexandria, Va., Chairman, AMA Board of Trustees.



Members Urged to Consider ISMA Disability Insurance

MORE members of the Indiana State Medical Association are being urged to consider participating in the long term disability insurance program which is endorsed by the Association.

The ISMA plan, solely independent of the AMA program which has encountered difficulties, has its own benefit and premium rate schedules and has been jointly developed through the careful study of the ISMA Commission on Medical Economics and Insurance and the administrators for the program, J. Russell Townsend Associates and the Continental Casualty Company.

The plan has been labeled sound and stable and is assured of continued success in direct proportion to voluntary participation by the Association's membership, according to the plan's administrators.

ISMA members who are not currently participants in the plan and who would like additional information and application forms should write to J. Russell Townsend Associates, 715 Board of Trade Building, Indianapolis 46204.

WANTED ! ! ! !

SHUTTERBUGS! "CRAFTY" WORKERS! "CANVAS-DABBERS"! FUN-SEEKERS!

WE invite YOU and/or your MATE to share your talents and interests in YOUR 1974 ISMA ART AND HOBBY SHOW, October 4, 5, 6, 7 and 8.

Address ALL applications and inquiries to:

Mrs. Harry Siderys, 9105 Kirkham Ct., Indianapolis 46260 or telephone 317-846-5030 before September 27, 1974.

Applicants will be further notified regarding final arrangements.

LOOKING FORWARD TO SEEING YOU IN OCTOBER!

ART AND HOBBY SHOW APPLICATION

Exhibitor _____ Phone No. _____

Address _____ City _____ Zone _____

EXHIBITS: Enter total No. items _____

MEDIUM	TITLE	SIZE

Special Note: I can ____ or cannot ____ help accompany the exhibits between the hours of ____ on ____ (date). You need not be an exhibitor to help with the exhibit.



ABSTRACTS, BOOK REVIEWS

ARTHRITIS

Sheldon P. Blau, M.D., and Dodie Schultz, Doubleday & Company, Inc., Garden City, N.Y., 1973.

Arthritis provides a broad spectrum of information on the many facets of arthritis. The author, a well-qualified internist, Chief of the Arthritis Clinic at Nassau County Medical Center, and a reputable academician, speaks with authority. His collaborator, Dodi Schultz, is a free-lance writer with a splendid publication record. The book is not intended to substitute for expert medical advice based on consideration of the individual patient. After defining terms, the authors describe the enormous impact of arthritis. Then they delve into the many varieties—the collagen diseases, gout, osteoarthritis, rheumatoid arthritis, the whole gamut. They don't neglect drugs, nutrition, or even sex. Finally, they take a forward look at research. The book can be wholeheartedly recommended for the more intelligent type of patient with this ubiquitous ailment. It is priced at $5.95.

W. D. SNIVELY, JR., M.D.
Evansville

ATLAS OF STRABISMUS SURGERY

Eugene M. Helveston, M.D., C. V. Mosby Company, St. Louis, 1973; 228 pages with 307 illustrations; $28.50.

For some time now there has been a real need for a comprehensive atlas for strabismus surgery, such as this present volume. This atlas presents an up-to-date collection of the recent advances of strabismus surgical techniques and the indications for their use.

The book begins with an excellent review of the surgical anatomy, consisting of the palpebral fissure variations, access through the conjunctiva, a complete description of tenon's capsule, the relationship of the extraocular muscles, their blood supply and the sclera. The complete understanding of these relationships is absolutely necessary for successful strabismus surgery. It then continues with the discussion of instrumentation, types of anesthesia and materials used for surgery. There is an excellent and unbiased discussion of the different technics and exposure of the extraocular muscles. The author proceeds with a detailed description of the technics used for recession, resection and surgery on the obliques, as well as muscle transposition procedures. Following this is a review of the complications of strabismus surgery with emphasis on the prevention and treatment. Chapter 12 is an excellent presentation of a logical scheme for the planning of strabismus surgery. It is exactly what the author states, a logical approach to surgery, and eliminates the witchcraft and cookbook approaches for which there is no place in strabismus surgery. The book concludes with a presentation of case reports.

This atlas is a concise, easily comprehended presentation of a difficult subject. The author has succeeded in accomplishing everything he stated in his preface. The atlas should be required reading for anyone performing strabismus surgery.

JAMES J. McCALLUM, M.D.
Indianapolis

COMMENTS IN SPORTS MEDICINE

Timothy T. Craig, editor, American Medical Association, Chicago, 1973.

Comments in Sports Medicine is a multiple-author text edited by Timothy T. Craig, Ph.D. Its major contributors include a cluster of authorities on the scientific aspect of sports. It was presumably reviewed by the Committee on the Medical Aspects of Sports, consisting of six M.D.s. Such topics as athletic accident prevention, injuries, equipment and facilities, communicable disease, drugs, athletics for girls, first aid, special problems, nutrition, hypnosis for athletes, quackery, and safety provide an inkling as to the broad coverage of the book. I was somewhat disappointed by the omission of mention of potassium deficit as an important cause of heat stress disease that occurs in acclimatized individuals whose sodium conservation is excellent (because of high production of aldosterone) but whose potassium excretion (also because of aldosterone excess) can lead to overt potassium deficit. But in this same area, the author's emphasis on providing water during workouts is certainly praiseworthy.

Every physician involved in any way in sports medicine should have this book in his library. To order, write Order Department, AMA Headquarters for publication OP-62, which sells for $5.00.

W. D. SNIVELY, JR., M.D.
Evansville

THE SOFT FOODS COOKBOOK

Anne S. Chamberlain, Doubleday and Company, Inc., New York City, 1973; 130 pages; $5.95.

The author reminds us that a "special diet" need not be difficult nor the patient be isolated from family meals. Many of the recipes sound delicious and festive and should give variety to both the patient and the family.

The preparations described are intended to be of help to patients who have problems chewing or swallowing. The recipes range from semi-soft to blended.

Miss Chamberlain restates the need to plan ahead by cooking several servings at a time and then freezing individual servings for future use. The book contains some excellent hints on ways to increase food values by using frozen and prepared foods found at your grocer's.

MILDRED RAMSEY
Indianapolis

POST-MORTEM

David M. Spain, M.D., Doubleday & Company, Inc., Garden City, N.Y., 1974.

Post-Mortem is the work of David M. Spain, M.D., currently director of pathology at Brookdale Hospital Medical Center in Brooklyn. In the book, Dr. Spain describes 12 important instances of unnatural death in which the pathologists elicited testimony from the dead. He demonstrates how the autopsy

can be a truth-seeking tool and how autopsies can serve as political and legal weapons. Among the sensational cases in which the findings of Dr. Spain played a key role are the case of the three slain civil rights workers in Mississippi, the Fred Hampton shoot-out, the New Haven Panther and the Alice Crimmins trials.

The contents page gives an inkling of the exciting tales to be found in this book—"Mississippi Autopsy," "Death in the Tombs," "Alice Crimmins in Wonderland," and "Cures Can Kill." Dr. Spain describes how officials have tried to hide his findings; nor are certain giant corporations guiltless—and Dr. Spain takes the stand against them.

Beyond the sensational aspects of this book is much basic information concerning the new science of forensic medicine. This book should provide not only escapist reading, but some downright useful information. I can recommend it for your all-too-few leisure hours. The book contains 296 pages and sells for $7.95.

W. D. SNIVELY, JR., M.D.
Evansville

RECENT ADVANCES IN STUDIES ON CARDIAC STRUCTURE AND METABOLISM, VOL. 2 — CARDIOMYOPATHIES

Edited by the late Dr. Eöors Bajusz and G. Rona, M.D., Ph.D., University Park Press, Baltimore, 1973; $39.50; some three-score collaborators from just about all five continents; copious references and illustrations; 842 pages.

Cardiomyopathies have been of great interest to me, lo, these many decades! I had reported cases before WWII. I'm looking now at a reprint of "Fiedler's Myocarditis" published in August 1957 in *Geriatrics* (two cases). Dr. G. E. Burch (starting on page 58) discusses the incidence of cardiomyopathies in the world-at-large. I find Table 2 (page 62 and on) most instructive. As I read the long list of possible causes—including allergy related—I went to Burch's latest edition of his thick volume on *The Heart* and perused it for further clues.

For all our vaunted knowledge, it becomes blindingly clear that we have a long—very long—path to travel before we become capable of making clinical diagnoses that we'll be able to follow through and furnish intelligent therapy. I'm not talking about the obvious alcoholics, allergic reactions or even such exotica (to me) as "Cardiac Failure in Ruminants Caused by Gousiekte" (a deadly South African weed).

This volume does make clear the fact that clinicians should give more—much more—thought to the various Cardiomyopathies in their differential diagnoses. A brief summary paragraph on page 73 thrusts this very point at us. It should be made required reading by us all!

As usual, the publisher has furnished the very best in binding, paper and printing. I failed to note any typographical errors.

ARNOLD LIEBERMAN, M.D.
New York City

RECENT ADVANCES IN STUDIES ON CARDIAC STRUCTURE AND METABOLISM — VOL. 3, MYOCARDIAL METABOLISM

Edited by N. S. Dhalla, Series Editor: G. Rona, University Park Press, Baltimore, 1973; $39.50; 878 pages, almost 200 contributors; copiously illustrated.

Ever since the discovery of the Crick helix model and the firm demonstration of the chemistry of the AMP, ADP and ATP, to say nothing of cyclic AMP (cyclic 3′, 5′-adenosine monophosphate), we have had a veritable knowledge explosion, completely altering our previous concepts of myocardial metabolism. In the December 1973 edition of *JISMA*, I made some comments on another symposium on just this topic. Last November, I attended a joint USA-USSR session on this vitally vibrant subject.

What can one say when perusing these magnificent articles giving us the very latest and newest? Gorgeous electron micrographs? Tables? You name it. It's there. No point in gilding the lily.

The "ordinary" M.D. or even the cardiac consultant will find this volume, on the whole, rather tough reading. Certainly, all hospital and medical school libraries should have these volumes on their shelves. The biochemical specialist would do well to ponder these monographs. The chapters on myocardial infarction could be read with profit by all of us. If not the entire chapter, then the summary, such as—say, on page 748; ditto pages 760, 771, etc.

Of course, the paper, binding and printing are up to their usual high standards. I really cannot find anything at which to cavil.

ARNOLD LIEBERMAN, M.D.
New York City

RECENT ADVANCES IN STUDIES ON CARDIAC STRUCTURE AND METABOLISM, VOL. 4, MYOCARDIAL BIOLOGY.

Edited by N. S. Dhalla, Series Editor: G. Rona University Park Press, Baltimore, 1974; $39.50, 614 pages; profusely illustrated; some 200 contributors.

My Ph.D. thesis was on "Calcium Metabolism" and was first published in the *Journal of Pharmacology and Therapeutics* as a series of 10 articles and then presented in summary form at an AMA meeting and in *JAMA* back in 1931. As I look at this gorgeous monograph, I remain all-but-dumfounded at the enormous progress made in the intervening four decades! In particular, let me call your attention to the chapter on "Role of Na-K activated Adenosine Triphosphate in the Transmembrane Transport of K and Na Relationships to the Inotropic and Electrophysiologic Effects of Digitalis" (page 107 on). Read the summary on page 116 anent the membrane transports. And then go on to the discussion on the tubular systems in myocardial dystrophies (page 186 on). And look carefully at the high magnification photograph on the opposing page!

What was said anent Volume 3 need not be repeated. The calcium metabolism, role of mitochondria, the sarcoplasmic reticulum and various calcium pump mechanisms only add to the overwhelming effect of the progress being made! That meeting at Winnipeg was certainly a great success. It may be a harbinger of the colossal results still to be published in Volume 5 of this series under the editorship of A. Fleckenstein. More power to all of them! We have glimpsed the mountain peaks; let us all proceed to climb them!

ARNOLD LIEBERMAN, M.D.
New York City

MEDICARE AND SOCIAL SECURITY: WHAT YOU'VE GOT COMING

Bruce Biossat, originally published in 1972 by Newspaper Enterprise Association, Inc., this being the fourth revised edition by Dolphin Books, Doubleday & Co., Inc., Garden City, N.Y., 1973; $1.95; 114 pages with index.

This small "paperback" is a concise and lucid explanation of our Medicare and Social Security system, including also some information on Medicaid. There also is a checklist of documents important for Social Security purposes.

There is a great deal in this book that should interest any adult American, including much that the average person does not know about the Social Security laws and regulations. Many changes were established in 1973. Furthermore, the use of plain English and elimination of legal and bureaucratic phraseology lightens the burden of maintaining one's attention on these subjects.

This would be an excellent book to have in one's office to aid in explaining such matters to patients and also to ease the path of one's secretary who handles such accounts. The index is good and makes this a really ready reference book. The price is right.

A. W. CAVINS, M.D.
Terre Haute

CURRENT SURGICAL DIAGNOSIS AND TREATMENT

J. Englebert Dunphy, M.D., professor of surgery and chairman of Department of Surgery, University of California School of Medicine (San Francisco), and Lawrence W. Way, M.D., associate professor of surgery, same university, and associate authors. Illustrated by Laurel V. Schaubert, Lange Medical Publications, Los Altos, Calif., 1973; first edition; 1075 pages plus 33-page appendix and index; $14.00. To be translated into Spanish. A second edition "will appear within two years."

There are 52 chapters, each encompassing a certain subject or a body region. The preface states: "This surgical text has been prepared with the needs of both medical students and practicing surgeons in mind." In perusing it, the reader is impressed by the degree to which this has been accomplished.

The various chapters all begin with a review of the anatomy and also, in many instances, the embryology of the organ system under consideration. Then follow succinct descriptions of the various diseases and pathological conditions associated therewith which come under the purview of the surgeon, together with treatment.

Each of the categories, or sections, is clearly set forth under a heading in uppercase type, easily picked out from the rest of the chapter, and at the end of each such section is a short bibliography, most of these references being to articles in journals rather than to textbooks. In addition, at the end of each *chapter* is a list of "General References." Recommendations for treatment are precise and clear.

The Appendix contains an alphabetical list of chemical constituents of blood and body fluids, with normal values, and short notations of disease conditions where they are found elevated or depressed. There are also nomograms for determination of body surface—children and adults. The index seems unusually good.

This book is remarkably homogeneous, considering the fact of 62 different authors. However, all but eight are from the University of California School of Medicine (San Francisco), which would, I believe, facilitate homogeneity, as it is the "home base" of Doctors Dunphy and Way.

Format is soft cover (plastic) resembling leather, and this may account for the price ($14.00). Personally, I favor this type of cover, as it is not only cheaper but is much easier to hold while reading than a hard cover. Typography and illustrations are excellent, the pages being printed in two columns, each of a width which facilitates reading. Would that more books were produced with such care!

A. W. CAVINS, M.D.
Terre Haute

THE PERSECUTED DRUG: THE STORY OF DMSO

Pat McGrady, Sr., Doubleday & Co., Inc., Garden City, N.Y., 1973; 372 pages; $7.95.

Mr. McGrady recently retired as Science Editor of the American Cancer Society and authored *The Savage Cell*, a book about cancer research.

His foreword reveals his point-of-view and his plan in writing the book, including an interesting question:

> "If DMSO is that good, why isn't it on every drugstore shelf in America? The answer to this question can be summed up in a single word—bureaucracy. . . . So, as it turns out, the purchaser of this book gets not a single, simple, straightforward account of a drug but three stories in one: the incredible performance of an unbelievable drug; the unlikely adventures of a fantastic government agency; and the problems of a man so good in a wicked world that his virtues are regarded as vices."



McGrady begins with a short chapter containing the history of dimethyl sulfoxide, from its discovery by Saytzeff in Russia in 1866, and its subsequent neglect, to its revival about 80 years later, chiefly as a solvent. It mixes readily with water, alcohol, oils (lipids) and benzene (among others). It is a by-product in the production of wood pulp and paper. An early medical use was in preservation of blood components and bone marrow by fast-freezing at very low temperatures. DMSO was found (by the British) to prevent formation of ice crystals, with apparently no harm to the cells.

Robert J. Herschler, a chemist at Crown Zellerbach Corp., Camas, Washington, noticed many oddities about DMSO, including its ability to be absorbed readily by plant twigs and also by human skin, carrying with it other substances such as dyes, pesticides, antibiotics and antifungal agents. He presented this knowledge to Dr. Stanley W. Jacob, associate professor of surgery at the University of Oregon Medical School. Dr. Jacob at once became fascinated by the many possibilities for medical use of a substance like DMSO, and began both clinical and laboratory studies.

When first introduced to DMSO, Jacob tried painting iodine on his arm, then applied DMSO over the spot. Then he "sat there watching the iodine disappear into the deeper regions of the skin. . . . he suddenly became aware of a strange thing. He could taste the DMSO!" This, of course, raised a multitude of possible therapeutic uses.

McGrady then describes the progress of Jacob's clinical and laboratory uses and experiments with DMSO, including reports of many astonishing results in difficult situations, such as burns, severe sprains, etc., and even in scleroderma and paraplegia from trauma to the spinal cord. The author writes in a dramatic style, yet he obviously has done much research on this subject and has interviewed many people, from such scientists as Jacob to James Lee Goddard, M.D., the FDA Commissioner (including a tape recording of this one).

While this book is loaded with clinical examples, reports of research on DMSO by *bona fide* scientists (in many countries) and findings published by firms such as Merck, through it all McGrady pursues an expose of the heavy handed bureaucratic tactics of the Federal Drug Administration in suppressing this drug and makes some startling charges against the FDA, including "the 'no-knock' system, the photocopying of private papers, bugging, punitive investigations, slander and libel, character assassination, forgery, lying and blackmail." To date, I have no knowledge of any libel suits against McGrady by the FDA, and in the book he quotes much material which backs up his accusations.

Physicians should be most interested in reading this book so that they may come to their own conclusions regarding the FDA and its "battle" against DMSO, which it has just recently released for limited veterinary use.

McGrady has assembled a masterful chapter (or two) of data concerning the decline in production of new drugs in the USA since the 1962 Kefauver-Harris Amendments to the Food and Drugs Act, and he is not the only author currently concerned about this. Furthermore, many so-called "free American doctors" are and should be concerned.

While McGrady's title is "The Persecuted Drug," etc., perhaps it should read "The Persecuted Clinical Researcher." All clinicians (and veterinarians), as well as those who believe in "the land of the free and the home of the brave," should read this book, even though it is a bit dramatic. We are becoming so used to being pressed in a mold by bureaucracy, it is difficult for us to stand aside for a clarifying view. My hat is off to Mr. McGrady.

A. W. CAVINS, M.D.
Terre Haute

Abstracts from Various Literature, Prepared by AMA

SMALL BOWEL INJURY FOLLOWING RADIATION THERAPY FOR CERVICAL CANCER

J. R. van Nagell, Jr., et al. (Univ. of Kentucky Medical Center, Lexington 40506).
Am. J. Obstet. Gynecol. 118: 163-167 (Jan. 15) 1974

In 271 patients with invasive cervical carcinoma treated by radiation therapy, total tumor and paracervical dose varied from 7,000 to 9,000 rads, and 5,000 to 6,000 rads was delivered to the lateral pelvic walls. Within 6 to 60 months following therapy, eight (2.9%) of these patients suffered small bowel obstruction in the absence of tumor. In the population studied, the thin, diabetic, hypertensive patient was found to be particularly susceptible to the development of small bowel injury following radiation therapy for cervical carcinoma.

RADIOLOGICAL EVIDENCE OF DOSE-RELATED RESPONSE TO LONG-TERM TREATMENT OF PAGET DISEASE WITH HUMAN CALCITONIN

F. H. Doyle et al. (Hammersmith Hosp. and Royal Postgraduate Medical School, London)
Br. J. Radiol. 47:1-8 (Jan.) 1974

Radiological observations in 28 patients with Paget disease of bone treated for 10 to 40 months with synthetic human calcitonin are presented. Response to treatment may be dose-related. No patient receiving a dose of 0.5 mg twice daily showed evidence of deterioration and five showed improvement. On a dose of 0.5 mg a day, three patients improved and four deteriorated. On 0.5 mg a week, four patients deteriorated and none improved.

REYE SYNDROME

J. A. Brunberg (Dept. of Pediatrics, David Grant Medical Center, Travis Air Force Base, CA 94535) and W. E. Bell
Arch. Neurol. 30:304-306 (April) 1974

Polio type 1 vaccine-like virus was isolated from spinal fluid, ileum, and brain tissue of a 7-year-old girl whose clinical course and postmortem findings were typical of Reye syndrome. Her history revealed previous immunization with seven courses of inactivated polio vaccine and close contact, three weeks before her illness, with a child recently immunized with oral trivalent attenuated poliovirus.

RADIATION-INDUCED HEAD AND NECK TUMORS

B. Modan et al. (Chaim Sheba Medical Center, Tel Hashomer, Israel)

Lancet 1:277-279 (Feb. 23) 1974

About 11,000 children irradiated for ringworm of the scalp and two matched control groups were retrospectively followed up for 12 to 23 years. The irradiated group had a significantly higher risk of both malignant and benign head and neck tumors, especially those in the brain, the parotid gland and the thyroid.

EFFECT OF LOW-DOSE HEPARIN ON INCIDENCE OF POSTOPERATIVE PULMONARY EMBOLISM DETECTED BY PHOTOSCANNING

G. Lahnborg et al. (K. Bergstrom, Dept. of Clinical Chemistry, Karolinska Sjukhuset, Stockholm)

Lancet 1:329-331 (March 2) 1974

Of 112 patients admitted for elective major surgery, 58 were treated with heparin, each receiving 5,000 units/12 hours for five days, starting two to five hours before operation. In this group, 11 patients (19%) had pulmonary embolism or deep vein thrombosis (DVT) or both. Of the 54 patients in the control group, 30 (56%) had pulmonary embolism or DVT or both.

COMPLEMENTARY ROLES OF CHEST RADIOGRAPHY, LUNG SCANNING, AND SELECTIVE PULMONARY ANGIOGRAPHY IN DIAGNOSIS OF PULMONARY EMBOLISM

D. C. Moses et al. (Univ. of Michigan Medical Center, Ann Arbor 48104)

Circulation 49:179-188 (Jan) 1974

The chest x-ray, perfusion lung scan, and selective pulmonary arteriogram were independently reviewed in 104 patients with suspected pulmonary embolism. Of the 45 patients with angiographically documented pulmonary emboli, 82% had perfusion scans interpreted as high probability of pulmonary embolism. Of 59 patients without angiographic evidence of pulmonary embolism, 85% had perfusion scans interpreted as low probability of pulmonary embolism, other or normal. Of the 41 patients with acute pulmonary embolism, only three had normal chest x-rays. In 26 (63%) the abnormality on perfusion scan was more extensive than that on chest x-ray. When both the scan and chest x-ray pointed strongly in the same direction, a correct diagnosis could usually be made, and accuracy was greater than when diagnosis was based on the perfusion scan alone. The lung scan was of limited value in patients with cardiomegaly or left heart failure.

IMPROVED MANAGEMENT OF SKIN GRAFT DONOR SITES WITH SILVER SULFADIAZINE DRESSINGS

J. R. Lloyd (1515 David Whitney Bldg., Detroit 48226)

Arch. Surg. 108:561-565 (April) 1974

The topical antimicrobial, silver sulfadiazine (Silvadene) was used to treat over 400 burn patients since August 1968. This experience included the use of Silvadene dressings on skin graft donor sites and two significant observations were made: The clinical healing time of the donor wound was reduced from a range of 12 to 21 days to 6 to 7 days, and the time interval between reharvesting donor sites was reduced from a range of 15 to 25 days to as little as 9 to 10 days. The Silvadene dressings are essentially painless, sometimes soothing and, moreover, the clinical significance of reduced reharvesting time is obvious in the patient with major burns where scarce autogenous donor sites must be reused as often as 10 times.

TRACHEAL OBSTRUCTION

S. Attar et al. (Univ. of Maryland Hosp., 22 S. Greene St., Baltimore 21201)

Ann. Thorac. Surg. 16:555-567 (Dec.) 1973.

Tracheal obstruction, a life-threatening emergency that requires immediate therapy, manifests itself by cough, wheezing, exertional dyspnea, hemoptysis, and respiratory arrest. Thirty-three patients with tracheal obstruction were studied: 17 had tracheal stenosis secondary to tracheostomy and ventilatory assistance, seven had primary tracheal tumors, and nine had either secondary tracheal tumors of extrinsic compression by esophageal or thyroid tumors. The diagnosis of tracheal obstruction was confirmed by roentgenograms of the trachea and bronchoscopy. The ideal treatment for tracheal obstruction caused by benign tracheal stenosis or malignant tumors is primary resection with end-to-end anastomosis. Cobalt therapy with or without surgical resection provides good palliation for extensive primary or secondary tracheal tumors. ◄

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The Woman's Auxiliary Reports to ISMA

Dear Doctor:



Here it is, late in May, and I'm writing this page for the July **Journal**. I'm sure that some of you will not even see this page, let alone read it, until November or December; but a few of you may tumble onto it while waiting in the hospital emergency room, record room or OB waiting room at some earlier date—perhaps on a hot summer evening. You may be tired and impatient, or you may be in a hurry to get somewhere but are killing time waiting for the delivery, the x-ray or laboratory report before completing your hospital mission.

This makes me wonder about what I should write that would be of interest to you under such probably varied circumstances.

In my inaugural speech I commented about the desirability of "togetherness" in our work, and I'd like to comment on some of the "togetherness activities" of physicians and their Auxiliary-member wives that I have had the pleasure of witnessing since I gave that speech in April. There's more of it than I realized.

This year, the members of the graduating class of I.U. Medical School held a dinner the night before graduation ceremonies to which were invited their wives, husbands and faculty. It was well attended, and was a very heart-warming experience for my husband and me. Awards were given by the students to their favorite professors; honor students were given their A.O.A. membership and many other awards were presented to other newly graduated physicians. We felt it was a very worthwhile project, enjoyed by all, and we hope that future classes will continue this event. We all remember our Senior Week activities and this would be a fine tradition that could add to one's fondest memories.

We have also attended Doctor Recognition Day in Birmingham, Ala. and AMPAC meetings in Michigan, Florida and Ohio, where not only the attendance of husbands and wives was great but also the interest in working "together" equally as great.

Working "together" will help American Medicine present a better image to the public.

Warmly,

Beth Bowen

Mrs. Otis R. Bowen, President

Announce PG Course on Alcoholism

Central States Addictions Institute, in cooperation with the American Medical Association, will conduct an intensive one-day Postgraduate Course on Alcoholism for Physicians, on Wednesday, July 31. The Course will be given at the American Hospital Association Headquarters, at 840 North Lake Shore Drive, Chicago. Registration fee of $35 includes luncheon.

To register: phone (312) 726-0821, or write to James W. West, M.D., Medical Director, Central States Addictions Institute, 122 South Desplaines Street, Chicago 60606.

Perinatal Medicine Course In Colorado in August

"Perinatal Medicine" is the subject of a continuing education course to be presented at Snowmass-at-Aspen, Colorado, by the University of Colorado School of Medicine on August 12 to 16. Write the Office of Postgraduate Medical Education, 4200 E. Ninth Ave., Denver 80220 for full details.

Conference at Stockholm Set By World Medical Association

The World Medical Association announces an International Conference on the Physician and Population Change to be held September 4 to 6, in Stockholm, Sweden. All physicians are invited to attend. For details write Sir William Refshauge, Secretary General, The World Medical Association, 10 Columbus Circle, New York City 10019.

Orthopedic Surgeons Announce Course On Early Care of Injured Athlete

"Early Care of the Injured Athlete" will be the subject of a postgraduate course sponsored by the American Academy of Orthopaedic Surgeons at the University of Michigan, Ann Arbor, from September 8 to 11. Write the Academy at 430 N. Michigan Ave., Chicago 60611 for full details and reservation blanks.

Childhood Trauma Symposium at Riley

A Comprehensive Childhood Trauma Symposium sponsored by the Indiana University School of Medicine and The James Whitcomb Riley Hospital for Children, will be held in Indianapolis at Stouffer's Indianapolis Inn on September 11 and 12, 1974.

Topics include: Child Abuse, Birth Trauma, Shock in Infants and Children, Post-traumatic Pulmonary Insufficiency, Autotransfusion, Disseminated Intravascular Coagulation, Burns, Ophthalmologic Trauma, Head and Spinal Cord Injuries, Orthopedic and Hand Injuries, Trauma to the Chest and Abdomen, X-ray Evaluation of the Childhood Trauma Patient and Emergency Room Organization, Care, and Triage.

Registration Fee is $50.00, banquet and luncheons.

For further information contact: Jay L. Grosfeld, M.D., Surgeon-in-Chief, James Whitcomb Riley Hospital for Children, Indiana University School of Medicine, 1100 West Michigan Street, Indianapolis 46202.

Polytomography Symposium Scheduled

The 10th two-day Symposium on Polytomography of the Temporal Bone will be given under the auspices of The Wright Institute of Otology at Community Hospital, Indianapolis, Indiana on September 28 and 29, 1974.

Subjects covered are: "Basic Anatomy of the Temporal Bone" and "Technique of Polytomography of the Temporal Bone" with demonstrations of normal tomograms. Pathological conditions revealed by polytomography, such as cholesteatoma, ossicular chain problems, otosclerosis, fractures, foreign bodies, tumors, and congenital anomalies are shown on original tomograms and the clinical applications discussed.

Number of registrants is limited to 18. Fee for the course is $150.

Inquiries should be directed to: The Wright Institute of Otology, Inc., Community Hospital of Indianapolis, Inc., 1500 North Ritter Avenue, Indianapolis 46219.

Eye and Ear Infirmary Schedules Annual Otolaryngologic Assembly

The Annual Otolaryngologic Assembly of 1974 will be held Oct. 26 through Nov. 1, 1974, in the Eye and Ear Infirmary of the University of Illinois Hospital. The Department of Otolaryngology of the Abraham Lincoln School of Medicine, University of Illinois at the Medical Center, offers a condensed basic and clinical program for practicing otolaryngologists under the direction of Emanuel M. Skolnik, M.D., with Burton J. Soboroff, M.D., as co-chairman. This program is designed to bring to specialists current information in medical and surgical otorhinolaryngology.

Interested otolaryngologists should direct their inquiries to the mailing address: OTOLARYNGOLOGY, P.O. Box 6998, Chicago 60680.

A separate, but correlated course, "Conference on Radiology in Otolaryngology and Ophthalmology" will be held this year on Friday and Saturday, November 29 and 30, under the guidance of Galdino E. Valvassori, M.D. For further information about the radiology conference, write to Professor Valvassori, Radiology Department, Abraham Lincoln School of Medicine, P.O. Box 6998, Chicago 60680.

Diseases of the Liver Course Set

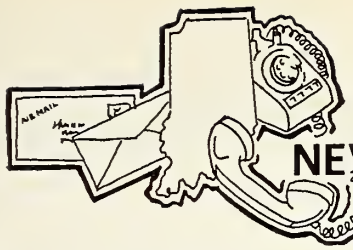
A postgraduate course on "Diseases of the Liver" will be conducted by the University of Miami School of Medicine at the Playboy Plaza Hotel, Miami Beach, from November 20 to 23. Leon Schiff, M.D. is the Director. Tuition is $150; for physicians in training $75, and for nurses $50. Inquiries may be addressed to Dr. Schiff, P.O. Box 520875 Biscayne Annex, Miami, Florida 33152.

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NEWS NOTES

Family Physician Academy Elects Officers, Directors for 1974-75

Dr. Ross L. Egger, Daleville, assumed the presidency of the Indiana Academy of Family Physicians recently and **Dr. Fred M. Blix, Ladoga,** was chosen president elect.

Dr. Kenneth E. Bobb, Seymour, is vice president and treasurer for 1974-75. **Dr. H. M. S. Bristol, Terre Haute,** is immediate past president.

Others elected were: Speaker and vice speaker, IAFP House of Delegates: **Drs. Malcolm Scamahorn, Pittsboro,** and **James M. Kirtley, Crawfordsville;** delegates to AAFP: **Drs. Wilson L. Dalton, Shelbyville, and William D. Ritchie, Evansville,** with **Drs. Alvin J. Haley and Egger** serving as alternate delegates.

Serving as directors are: **Drs. Charles Hachmeister, Evansville; Jerald L. Andrew, Fort Wayne; Daniel H. Cannon, New Albany; Richard W. Wagner, Huntington,** and **Marvin C. Christie, Beech Grove** (terms ending in 1975).

Also, **Drs. Paul Siebenmorgen, Terre Haute; George M. Ellis, Jr., Connersville; Warren L. Bergwall, Muncie,** and **Paul A. Williams, Rensselaer** (terms ending in 1976).

Directors whose terms will expire in 1977 are: **Dr. Bobb, Drs. Marshall Seat, Washington; L. Louis Frank, Jr., South Bend,** and **William G. Grosso, East Chicago.**

Genetic Disease Research Funded

The Riley Children's Hospital will receive a federal grant of $711,813 for the establishment of a major center for research in genetic diseases. This will be the 10th such center to be set up by the Health, Education and Welfare Department. It is the first in the Midwest. Over the next five years as much as $2 million could be given to the new center for study of diagnosis, treatment and prevention of hereditary diseases.

Dr. Sprague Gardiner Named Distinguished Fellow

Dr. Sprague Gardiner, Indianapolis, was recently named a Distinguished Fellow of the American College of Obstetricians and Gynecologists. Dr. Gardiner is the second ACOG Fellow to be so honored. He was cited in particular for his 15 years of dedicated service as a member of the ACOG Executive Board and his exceptional service as president of the College.

Aid Available for Establishing Emergency Coronary Care Systems

The Advanced Coronary Treatment Foundation (ACT Foundation) of 350 Grove St., Somerville, N.J., 08876, is organized to aid in the establishment of emergency coronary care systems in cities and towns throughout the U.S. Inquiry addressed to the Foundation will produce information on how to establish such systems.

Family Practice Residents Awarded Master's Degree

Ball State University recently awarded a Master of Science degree to each of three physicians who had just completed a three-year family practice residency at the Ball Memorial Hospital. Francis Pisney, M.D., of Lime Springs, Iowa; George Kirkpatrick, M.D., of Pittsburgh, Pa., and Charles Driscoll, M.D., of Keokuk, Iowa received the degree in recognition of the fact that the three-year residency includes training in the teaching of family practice medicine. **Dr. Ross Egger, Daleville,** head of the Ball Hospital Family Practice Clinic, designed the residency to emphasize behavioral science and the teaching of families on how to maintain health.

Announcement was recently made that the hospital's family practice residency program will receive a Public Health Service Training Grant of $214,314 to furnish a stipend to six physicians who will spend two years in residency training, as well as funds for remodeling the family practice clinic and buying audio-visual supplies.

Foundation for Blind Offers Film

A new film which deals with the integration of visually handicapped youths into sighted activities is available from the American Foundation for the Blind, 15 W. 16th St., New York City 10011. The film is 16 mm, color, and is 6½ minutes long. The rental fee is $1.50 per screening. A handling fee of $4.50 is charged for each shipment.

Brown County Museum to House Doctor's Office Furnishings

A group of civic organizations in Brown County is working to establish a Brown County museum complex to be ready for the 1976 Bicentennial celebration. The community center in Nashville, a large log structure, will be the museum. **Dr. Robert Seibel** has donated the office furnishings of Dr. Ralphy as a part of the display. Dr. Ralphy, whose personality and practice were memorialized in *The Journal* recently, practiced in Brown County in the 1800s.

Represents Smith Kline & French

William Benford, formerly System Manager for Gary Communications Group in Gary, will represent Smith Kline & French Laboratories in the Gary area.



ISMA PRESIDENT JOE DUKES, M.D., Dugger (center), was photographed at the Illinois State Medical Society's President's Night festivities at the group's annual meeting recently. With him are Dr. J. M. Ingalls, Paris, Ill., president elect, and Dr. Frank Jirka, River Forest, a past president of the Illinois State Medical Society.

Dr. Farquhar Elected Chairman Of Emergency Services Committee

Dr. John S. Farquhar, Fort Wayne, was elected permanent chairman of the Indiana Emergency Medical Services Commission recently.

Governor Otis R. Bowen had named the new agency in compliance with a law enacted by the 1974 General Assembly. Under the new law, the commission is to report to the Governor with recommended standards for training of persons involved in emergency medical care and for equipment. No regulations are to be promulgated until after the 1975 legislature meets and has a chance to review the proposed standards.

Dr. Rawlins Is Guest Speaker

Dr. Carolyn M. Rawlins, Munster, discussed "The Father's Role" at the Calumet Area La Leche League's **"Couples Night"** recently. A new film, "Talking about Breastfeeding" was also shown.

Arthritis Foundation Elects

Dr. Neal C. Pitts, Bluffton rheumatologist, was elected president of the Indiana Chapter of the Arthritis Foundation at the group's annual meeting.

Other officers elected were: **Dr. Edward Gabovitch, Indianapolis,** first vice president; **Dr. Alfred Symmes, Indianapolis,** second vice president.

Dr. Hoberock Certified

Dr. Thomas R. Hoberock, Bedford, has received word that he has been certified by the American Board of Surgery. He completed his residency last summer at Louisville, Ky. His subspecialty training is in vascular surgery.

Dr. James O. Ritchey Honored

A $50,000 gift to establish a pulmonary function laboratory in Methodist Hospital, Indianapolis, in honor of **Dr. James O. Ritchey,** has been announced. The gift is in tribute to Dr. Ritchey from the family of the late Thomas D. Adams, Sr., an Indianapolis businessman who died in 1972.

Dr. Ritchey is former president of the Methodist Hospital medical staff and former chairman of the Indiana University department of internal medicine.

College of Surgeons Elects

Dr. Austin L. Gardner, Indianapolis, was elected president of the Indiana Chapter of the American College of Surgeons at its annual meeting in Evansville.

Dr. Edwin C. Mueller, LaPorte, was named president-elect, while **Dr. John Glover, Indianapolis,** was elected secretary-treasurer. Elected counselors were **Drs. William C. Brennan, Highland; Irvin Heimburger, Evansville; Lawrence Lawson, Muncie; Robert Nagan, Indianapolis, and Ralph Carlson, Evansville.**

Elected President by Proctologists

Dr. Daniel D. Thomas, Gary, was elected president of the International Academy of Proctology at the group's 26th Annual Congress and Teaching Seminar Convocation May 9 in Montreux, Switzerland. The Academy is the largest society of its kind with a membership of nearly 1,000 physicians and surgeons throughout the world.

Participate in Seminar

Speakers at an information seminar at the Spring Conference of the Northeastern Area Council of Hospital Auxiliaries at Lutheran Hospital, Fort Wayne, recently were: **Drs. John K. Dyer** and **Jack W. Patterson,** representing the Lutheran Hospital renal unit and St. Joseph Hospital's burn unit.

Dr. Jeans on APA Program

Dr. Robert F. Jeans, Richmond, a Fellow of the American Psychiatric Association, was invited to discuss the paper of Dr. Robert Post of the National Institute of Mental Health at the annual meeting of the American Psychiatric Association in Detroit in May.

Guest Speaker, Election Close Year For Terre Haute Academy of Medicine

The last of the 1973-74 Scientific Lecture Series of the Terre Haute Academy of Medicine was held on June 7, with Dr. Philip Bromberg, professor of medicine at the Ohio State University Hospital (Columbus), lecturing on "Acute Respiratory Distress in Adults."

The Academy has, for the past several years, been sponsoring visiting scientific lecturers from various medical centers who discuss and present medical problems in their fields of specialty. The monthly meetings are held from September to June, and are attended by physicians and paramedical personnel in the Wabash Valley area.

New officers were elected, and **Dr. J. F. Pangan,** president, will be succeeded by **Dr. Paul Siebenmorgen; Dr. John Hetherington** will be vice-president, and Dr. Kenneth Anderson will continue as the secretary-treasurer.

Appointments Made by Governor

Drs. Robert P. Acher, Greensburg; Wilson L. Dalton, Shelbyville, and Jack H. Hall, Indianapolis, have been named by **Governor Otis R. Bowen** to the Indiana Medical Education Board.

Dr. Frank C. McDonald, New Castle, has been appointed to the New Castle State Hospital Advisory Committee.

Dr. John Records, Franklin, will serve on the newly created Addiction Services Advisory Committee, as will **Dr. James O. Price, Indianapolis.**

Dr. Eugene Roach, Indianapolis, was appointed to the Committee for the Study of Mental Health Laws; **Dr. Joseph D. McPike, Carmel,** State Civil Defense Advisory Council, and **Dr. Gordon Brown, Indianapolis,** to the Planning and Advisory Board to the Division of Mental Retardation.

Marion Laboratories Expands Program

Marion Laboratories announces that its PRE Rx® Program will be expanded to cover all oral prescription drugs marketed by the company. At the same time, all unsolicited sampling of prescription products will be discontinued.

Dr. Wei-Ping Loh Reelected

Dr. Wei-Ping Loh, Gary, has been reelected president of the American Chinese Medical Society headquartered in New York City. The society is in its 11th year of service and has several hundred members in the different parts of the United States and Canada.

Dr. Loh was also designated as vice president of the American Center for Chinese Medicine in Washington, D.C.

Rural Physician Recruitment Kit Ready

Rural communities in need of physicians may obtain advice and assistance in recruiting efforts by use of the new AMA information packet. An 11-page booklet and accompanying supplementary materials entitled "Action Plan for Physician Recruitment" may be obtained free by writing Physicians' Placement Service, AMA, 535 N. Dearborn, Chicago 60610. The effect of the plan is to put the main effort and the management of the recruiting where it belongs and must be, to be effective—in the community itself. Advice is included as how to organize a recruitment committee, whom to contact for assistance, how to sell community life style and how to develop alternative health care delivery systems. The plan counsels the community to work with state and local medical societies and nearby physicians.

Dr. Lall Montgomery Honored

Dr. Lall G. Montgomery, Muncie, received the honorary degree of LL.D. recently at Ball State University in recognition of his work in elevating the standards for education and certification of medical technologists and for his work in clinical pathology.

New Public Affairs Booklet Announced

"Helping the Handicapped Teenager Mature" is the title of Public Affairs Pamphlet No. 504. It is authored by Evelyn West Ayrault to outline some common problems facing the handicapped teenager and to discuss what parents can do to help. Price is 35 cents. Write Public Affairs Committee, 381 Park Avenue South, New York City 10016.

AMA Contract Renewed

AMA's contract for Project USA has been renewed until June 30, 1975. The project places physicians to serve as short-term replacements for National Health Service Corps physicians in areas of critical medical personnel shortages. Under the new contract, the AMA will also recruit physicians for long-term assignments in the NHSC. Physicians receiving long-term assignments will be government employees, either members of the Commissioned Corps of the Public Health Service or Civil Service. Project USA physicians will be reimbursed by the AMA.

Calls for Acceptable Death Definition

The president-elect of the American Bar Association, James D. Fellers, in addressing the International Conference on Legal Medicine, stressed the necessity of adopting a universally acceptable definition of death. This is necessary, not only for the purposes of organ transplantations, but in the probating of wills and in determining the cause of death in criminal action. The problem is the joint responsibility now of the ABA's newly created Committee on Law and Medicine and the Research and Education Committee of the American College of Legal Medicine.

W. D. Gatch, M.D.

A resume of the life of W. D. Gatch is being compiled for historical purposes. Acquaintances and former associates of Dr. Gatch are invited to write to Malcolm Herring, M.D., 1000 Walnut St., Apt. 501, Philadelphia, Pa., 19107, to inform him of anecdotes and reminiscences suitable for recording.

Schedule for Upcoming NCME Programs

Here are the playing dates and upcoming programs to be distributed by The Network for Continuing Medical Education (NCME):

July 15-Aug. 11 SNAKEBITE, with Findlay E. Russell, M.D., Professor of Neurology and director, Laboratory of Neurological Research, University of Southern California School of Medicine, Los Angeles.

SKIN TESTING FOR TB, with John A. Crocco, M.D., Director of Pulmonary Disease Section, St. Vincent's Hospital and Medical Center, New York, and Downstate Medical Center, Brooklyn.

PARASITIC INFESTATION: LOOK FOR LICE, with Silas E. O'Quinn, M.D., Professor of Dermatology and Dean of Medicine; and Harold Trapido, Ph.D., Professor of Tropical Medicine and Medical Parasitology, both at Louisiana State University School of Medicine, New Orleans.

Aug. 12-Sept. 8 RECEPTOR DRUGS: TIME BORROWERS IN SHOCK, with Leon I. Goldberg, M.D., Professor of Medicine and Pharmacology, Director of Clinical Pharmacology, Emory University School of Medicine, Atlanta, Georgia.

LOCAL ANESTHESIA: THREE EFFECTIVE TECHNIQUES, with William C. North, M.D., Professor and Chairman, Department of Anesthesiology, University of Tennessee, Memphis.

THE PROBLEM PELVIC, with Philip Sarrel, M.D., Associate Professor of Obstetrics and Gynecology, Yale University Medical School, New Haven.

For more information about NCME, write The Network for Continuing Medical Education, 15 Columbus Circle, New York, N.Y. 10023.

(Program scheduling subject to change)

Richmond Hospital Wins Appeal

Reid Memorial Hospital, Richmond, has won an appeal for $711,000 in Medicare and general revenue funds which the Cost of Living Council originally had ruled were not allowable. The hospital, which is undergoing an expansion program, won the case when the increased costs of expansion were recognized by COLC.

Hoosier Science Students Win

One Hoosier student was the recipient of an AEC Certificate of Achievement in the International Science and Engineering Fair at Notre Dame recently. Ten such awards were made nationally for excellence in nuclear and energy-related exhibits. Michael R. Miller, 15, freshman at Belzer Junior High School, Indianapolis, received the award for his "Experimental Study of Nuclear Structure." With the certificate goes an invitation for each winner and his science teacher to attend an expense-paid "Nuclear Research Orientation Week" in August at the Argonne National Laboratory. Ten other students received honorable mention and will be alternates for the Argonne study tour. Among the ten were three Hoosiers: Albert Bates III, 17, senior, Elston Senior High School, Michigan City; Daniel Adam Wegener, 14, freshman, Eastwood Junior High School, Indianapolis; and Lawrence A. Wiedman, 18, senior, New Haven High School, Fort Wayne.

Medical Staffs Elect Officers

Dr. Leo R. Nonte has been chosen president-elect of the Deaconess Hospital medical staff. **Dr. Ray H. Burnikel** is the new president. **Dr. Ned P. Rule** was chosen secretary-treasurer, while **Drs. Edward L. Brundick and Irvin L. Heimburger of Evansville and Dr. L. John Vogel, Mt. Vernon,** were elected to the Executive Council. Continuing on the council for the second year will be **Drs. Sam B. Baker and Thomas E. VonderHaar of Evansville and Dr. Terry A. South, Poseyville.**

Dr. Eugene Gillum, Portland, has been selected as the new chief of the Jay County Hospital medical staff, succeeding **Dr. George Donnally, Geneva.**

Dr. Edwin B. Bailey, was serving as chief of staff at the new Greene County General Hospital at the time of his recent death. **Dr. George E. Moses, Linton,** vice chief of staff, and **Dr. Carl M. Porter, Jasonville,** secretary.

Dr. Arlington M. Hudson, Connersville, is the new chief of staff at the Fayette County Memorial Hospital, succeeding **Dr. Francis B. Mountain.**

Dr. O'Neill Assumes Chairmanship

Dr. Martin J. O'Neill, Valparaiso, has assumed the chairmanship of the ISMA Commission on Emergency Medical Service, succeeding Dr. John Suelzer, Indianapolis.

Denver Site of Ostomy Meeting

The annual meeting of the United Ostomy Association will be held at the Hilton Hotel in Denver on August 15 to 17. Members from almost 250 groups in the U.S., together with physicians and other professionals who are engaged in the care of all kind of ostomies will attend. A copy of the program and other details may be obtained by writing Mrs. Carol Ann Wilson, 7363 Cortez Lane, Boulder, Colorado 80303.

Dr. Rodney Mannion Appointed

Dr. Rodney A. Mannion, LaPorte County, has been appointed to the Editorial Board of *The Journal.*

Dr. Mannion has been a contributor of book reviews for a number of years and a new series of articles by Dr. Mannion on medical men in literature began in the March issue with an article on Sir Arthur Conan Doyle.

A diplomate of the American Board of Urology and a Fellow of the American College of Surgeons, Dr. Mannion received his M.D. from Loyola University, Chicago, in 1956.

Named Blood Bank Technologist

Donald W. Barnhart, Indianapolis, was certified as a medical technologist recently by the American Association of Blood Banks. Barnhart and 116 other technologists just passed comprehensive written and practical examinations for this designation. The Association has now certified a total of 1125 blood bank technologists.

Offer Booklets on Cancer Clinical Staging Systems

Nine booklets in a series on clinical staging systems for cancer are now available free of charge from the American Joint Committee for Cancer Staging and End Results Reporting. The booklets cover the reporting of cancer survival and end results and the staging systems for the pharynx, the oral cavity, stomach, larynx, uterus, breast, lung and esophagus. Write the committee at 55 E. Erie St., Chicago 60611.

Military Bonus Announced

All military physicians in the grade of colonel and below are eligible for an annual bonus of $13,500, excepting only those undergoing intern or initial residency training and doctors fulfilling an initial obligation of four years or less. An M.D. joining up at the completion of residency training could draw as much as $32,000 total salary. Special pay and the bonus for medical corps officers are necessary to encourage an equilibrium between military pay and the income which is typical of private civilian practice.

Dr. Robert Rohn Honored

Dr. Robert J. Rohn, Indianapolis, a member of the faculty of the Indiana University School of Medicine since 1950, has been named Bruce Kenneth Wiseman Professor of Medicine. He also serves as cancer coordinator for the medical center.

Additional Coverage Offered

Indiana Blue Cross and Blue Shield are offering additional coverage options, including $50,000 Major Medical for Medicare recipients and for those under age 65 who have individual non-group insurance. The increase in Major Medical is up from $10,000 for Medicare and up from $15,000 for individual members. ◄

County, District News

First District

New officers elected at the annual meeting of the First District Medical Society on May 9 at Evansville were: Dr. Albert S. Ritz, president; Dr. Martin J. Bender, vice president; Dr. John H. Barrow, secretary-treasurer; Dr. Bernard Rosenblatt, trustee until 1977, and Dr. E. DeVerre Gourieux, alternate trustee to serve the unexpired term of Dr. Rosenblatt until October 1976. All are of Evansville except Dr. Barrow, who practices at Dale, Spencer County.

Third District

The Third District was honored by having a member county win the Silver Dish award for the 25-100 member class. Mrs. Abner Bennett, State Chairman of AMAERF, presented the award to the Clark County AMAERF at the Regional Workshop. This award was for raising the most money per capita in the 1973-1974 campaign. Mrs. Claude Meyer, wife of the Third District President, was the Clark County Chairman for AMAERF. Our congratulations to one of our counties for a job well done again this year.

Fifth District

Dr. Paul Humphrey, Terre Haute, was elected president of the Fifth Trustee District at the May 22 meeting held at Turkey Run State Park. Dr. Fred Dierdorf, also of Terre Haute, was elected secretary-treasurer. Featured speaker at the afternoon meeting and again after dinner was Dr. George Crane.

Sixth District

At the Sixth District Medical Society's annual meeting Dr. Davis W. Ellis, Jr., Rushville, was elected president; Dr. William F. Kerrigan, Connersville, vice president, and Dr. Clarence G. Clarkson, Richmond, secretary-treasurer. Dr. Frank Green, Rushville, was reelected to the Blue Shield Board.

The 1975 meeting will be held at Richmond.

Seventh District

Dr. Ray D. Miller, Martinsville, acceded to the presidency of the Seventh Trustee District at the meeting on June 5 held at the Speedway Motel, Indianapolis, and Dr. Malcolm O. Scamahorn, Pittsboro, was re-elected secretary-treasurer. Dr. John M. Records, Franklin, is the new president-elect. Trustees Drs. John O. Butler and Donald McCallum, Indianapolis, were reelected, both to hold office until October 1977.

Eighth District

Dr. Eugene M. Gillum and Dr. James S. Fitzpatrick, both of Portland, were elected president and secretary of the Eighth District Medical Society at the group's annual meeting at the Anderson Country Club on May 29.

Twelfth District

There has been a change of date for the 12th District meeting. It will be held on September 19 at Fort Wayne.

Officers have recently been elected by a number of county medical societies, as follows:

Adams

New president is Dr. Hyung Soo T. Lee, Decatur, Dr. Robert L. Boze of Berne continues as secretary.

Allen

Dr. Robert Schmoll is the new president; Dr. Charles Aust, president-elect; Dr. Herbert Acker, secretary; Dr. George Irmscher, treasurer. Named to the board for three-year terms were Drs. Richard Juergens, Jerry Stucky, Harry Tunnell and Robert Voorhees. Drs. Emory Hamilton and Arthur Hoffman were elected to the Medical Society Foundation.

Bartholomew-Brown

Dr. Bryan E. Nelson, Columbus, will serve as president, and Dr. Terry L. Frederick, also of Columbus, will serve as secretary.

Fountain-Warren

Dr. Atilano S. Salvo, Williamsport, is the new president; Dr. Theodore Person, Veedersburg, continues as secretary. Drs. Max N. Hoffman, Covington, and Dr. Salvo will be delegates, and Drs. Lowell R. Stephens and Dr. Carl Nelson, alternate delegates. Drs. Salvo and William Ringer to serve on the Board of Censors.

Hancock

Dr. James T. Anderson, Greenfield, will serve as president, and Dr. William Rhynearson, Fortville, will continue as secretary.

Johnson

Dr. John E. Gilliland, has been elected president and Dr. Steven A. Weber, has been reelected secretary. Delegates will be Drs. Joseph W. Young and John M. Records. All are of Franklin.

Marshall

Drs. Marshall E. Stine, Bremen, and James N. Hampton, Argos, have been named president and secretary.

Putnam

Dr. Fred E. Haggerty has been elected secretary; Dr. John Ellett, Jr., Coatesville, continues as president.

St. Joseph

Drs. Gordon C. Cook, South Bend, and David Spalding, Mishawaka, have been elected president and secretary, respectively.

Owen-Monroe

Serving as president will be Dr. Robert D. Robinson, Jr., while Dr. Kermit Q. Hibner will serve as secretary; both are of Bloomington.

Vanderburgh

President: Dr. C. C. Young; president-elect, Dr. R. W. Nicholson; treasurer, Dr. John A. Bizal; Board of Directors: Drs. Donald C. Buehner, John F. Lawler; Board of Censors: Dr. John E. Alexander; delegates: Drs. Forrest F. Radcliff, L. Ray Stewart, John D. Wilson; alternate delegates: Drs. William H. Getty, Thomas P. Krueger and James A. Marvel.

Wayne-Union

President: Dr. Glen A. Ramsdell; president-elect: Dr. Charles Loomis; secretary: Dr. Frank Deanovic; treasurer: Charles Farmer; delegates for Wayne County: Dr. Tom S. Shields and James Daggy, with Drs. Glen Ward Lee and Joseph Zore as alternate delegates, and Dr. W. B. Williams as Union County delegate and Dr. Artemio Joco, alternate.



TAX TIPS

by LAWRENCE A. JEGEN, III

Mr. Jegen is a professor of law at Indiono University Indianapolis Law School, specializing in taxotion, business associotions ond estate planning. Professor Jegen urges the reoder to consult the reoder's lawyer before applying the data in this article to o porticular fact situation.

Due to the magnitude of the topic which is discussed herein, I have prepared more than one article in order to adequately cover the subject. This first article concerns a relatively recent ruling which was issued by the Internal Revenue Service. It is imperative to understand the fundamentals of this ruling before reading the next article. In fact, the reader should consider duplicating this article in order to review it just before reading next month's article. I believe that perusing the articles will be quite rewarding to you.

Frequently, a parent who devoted much of his life developing a sole-proprietorship (e.g., a farming business) or who has acquired a significant amount of land (or other property—e.g., stock in a closely held or public corporation) will want to transfer the property to his children. However, often he will need the income from the property for the remainder of his life. And often the children cannot afford to purchase the property by a lump-sum payment of cash.

In addition, the parent and the children are wise enough to realize the impact of the federal estate tax and the Indiana inheritance tax upon the parent's estate—should the parent die, while owning the property.

Now, there certainly are many sensible solutions to this brief statement of facts. But I wish to comment on one which is not used too frequently, largely, I believe, because of the misunderstandings about the results of this solution. Thus, I shall comment upon the disposition of the parent's property by a sale to his children who agree to pay the parent certain amounts (generally, monthly) for the remainder of the parent's life. This arrangement is called a "private annuity," and the general federal tax consequences are discussed in Rev. Rul. 69-74, 1969-1 C.B. 43.

The facts of this ruling are that a father, whose life expectancy was 10.1 years, owned property (a capital asset) which had an adjusted basis of $20,000 and a fair market value of $60,000. The father sold the property to his son in exchange for the son's legally enforceable promise to pay the father an annuity (for the life of the father) in the amount of $7,200 per year—i.e., $600 per month. The results described in the ruling are somewhat different than the ones presented herein because the computations in the ruling were based upon annuity tables which are no longer used for this purpose. That is, a similar transaction which is entered into today would utilize U.S. Treas. Regs. §25.2031-9(f), which are annuity tables based upon a 6% interest factor (and which differ in certain other respects from the prior 3% tables).

Using the new tables, the excess of the fair market value of the property ($60,000) over the present value of the annuity ($42,749, per tables) is a gift from the father to the son. The amount of the gift, for gift tax purposes, is $17,251 ($60,000 -$42,739).

The capital gain realized from the transaction is the excess of the present value of the annuity ($42,749) over the adjusted basis of the property to the father ($20,000), namely, $22,749. This capital gain is reported by the father, as the payments are made to the father, over the father's life expectancy—namely, over 10.1 years. Thus, the capital gain which is to be reported by the father is $2,252 ($22,749 ÷ 10.1).

The amount of ordinary income to be reported by the father for the first 10.1 years is the excess of the payments received by the father each year—namely, $7,200, over the sum of the portion of the $7,200 which is capital gain—namely, $2,252, and the portion of the payments which is considered to be allocable to the adjusted basis of the property to the father—namely, $1,980 (27.5% of $7,200). The 27.5% (referred to as an exclusion ratio) is determined by dividing the adjusted basis of $20,000 by the expected return to the father under the agreement of $72,720 (10.1 x $7,200), i.e., $20,000 ÷ $72,720, which equals 27.5%.

After the capital gain has been completely reported by the father—namely, after 10.1 years, the father must report all gain as ordinary income. The amount of the ordinary income is the excess of the payments received by the father each year—namely, $7,200, over the portion of the $7,200 which is considered to be allocable to the adjusted basis of the property to the father—namely, $1,980 (27.5% of $7,200). Thus, the amount of ordinary income to the father after 10.1 years, if he continues to live, is $5,220 ($7,200 -$1,980).

There are several advantages (and disadvantages) of the sale of property by the father to his children under the private annuity arrangement. These and other points will be discussed in next month's article.

Deaths

Benjamin D. Braun, M.D.

Dr. Benjamin D. Braun, who practiced for 30 years in East Chicago, prior to his retirement in 1970, died Feb. 20 in Sarasota, Fla., where he has lived for the past four years. He was 68.

A 1929 graduate of the University of Illinois Medical School, Dr. Braun was an intern and resident at Michael Reese Hospital, Chicago. He served as head of the radiology department at St. Catherine Hospital for 30 years and was also Clinical Assistant Professor of Radiology at the University of Illinois College of Medicine in Chicago. He practiced in Chicago prior to coming to Lake County.

A member of the Lake County Medical Society, he was also a member of the Radiology Society of North America and the American Medical Association.

Joseph Rilus Eastman, Jr., M.D.

Dr. Joseph R. Eastman, Jr., 59, retired Indianapolis surgeon, died April 20 in Cold Spring Road Veterans Administration Hospital, Indianapolis.

He had served on the staffs of St. Vincent and Methodist Hospital for several years. From 1964 to 1969 he was associated with the Veterans Administration's downtown Indianapolis office.

A 1941 graduate of the Indiana University School of Medicine, Dr. Eastman served in the Marine Corps in World War II aboard the U.S.S. Iowa in the Pacific and was a commander in the Medical Corps of the Naval Reserve.

A Fellow of the American College of Surgeons, he was a member of the Marion County Medical Society and the American Medical Association.

Nicholson J. Eastman, M.D.

Dr. Nicholson J. Eastman, 78, Baltimore, Md., died Sept. 28, 1973 in the Greater Baltimore Medical Center.

A renowned gynecologist, Dr. Eastman was a 1921 graduate of the Indiana University School of Medicine and served on the faculty of the Johns Hopkins University School of Medicine in Baltimore and the Peking Union Medical College in China. He was formerly chairman of the Section on Obstetrics and Gynecology of the American Medical Association and a past president of the American College of Obstetricians and Gynecologists, American Academy of Cerebral Palsy and the American Gynecological Society.

Henry J. Faul, M.D.

Dr. Henry J. Faul, 68, an Evansville physician and surgeon for almost 40 years, died April 1.

He opened his office in Evansville in 1934 after postgraduate work at the Mayo Clinic in Rochester, Minn. A graduate of the University of Michigan Medical School, Dr. Faul completed his internship and surgical residency at St. Agnes Hospital, Baltimore, Md.

Dr. Faul served as a major in the Army Medical Corps during World War II and his decorations included the Bronze Star and five battle stars.

In 1948 Dr. Faul served as temporary head of the City-County health department at Evansville. He was a member of the Vanderburgh County Medical Society and the American Medical Association.

Paul Jones Fouts, M.D.

Dr. Paul J. Fouts, Indianapolis hematologist, died Sept. 5, 1973. He was 68.

A 1929 graduate of the Indiana University School of Medicine, he interned at Boston City Hospital, Boston, Mass. He retired in 1970 from the Lilly Clinic at Marion County General Hospital and maintained a private practice. He was the author of more than 50 scientific papers and had served as clinical professor of medicine at the medical school.

During World War II he served in the Medical Corps and later was chief of outpatient service at Walter Reed Army Hospital, Washington, D.C.

Dr. Fouts was a diplomate of the American Board of Internal Medicine, a Fellow of the American College of Physicians, and was a member of the American Federation of Clinical Research, the American Hematological Society, the American Society for Clinical Investigation, the American Society of Internal Medicine, the Central Society for Clinical Research and the International Hematological Society. A member of the Marion County Medical Society since 1933, he was also a member of the American Medical Association.

James W. Griffith, M.D.

Dr. James W. Griffith, Sheridan, died at home April 12. He was 78 and had practiced in the Sheridan area since the 1920s.

After graduation from the Indiana University School of Medicine in 1920, he interned in Philadelphia.

He was on the staffs of Witham Memorial Hospital, Lebanon, and Methodist Hospital, Indianapolis. He was a veteran of both World Wars.

In 1966 he became a Senior Member of the Indiana State Medical Association and he became a member of the 50-Year Club in 1970. He was also a member of the Hamilton County Medical Society and the American Medical Association.

Thomas A. Rafalski, M.D.

Dr. Thomas A. Rafalski, 48, Indianapolis, died in an auto accident April 25 at Indianapolis.

A 1954 graduate of the Indiana University School of Medicine, Dr. Rafalski served his internship in St. Francis Hospital at Peoria, Ill., and split his residency between Chicago's West Side Veterans Administration Hospital and Marion County General, Indianapolis.

An Army veteran of World War II, he was a member of the medical staffs at St. Vincent, Methodist, Winona Memorial and Marion County General hospitals and at Indiana University Medical Center. He was an associate faculty member at the I.U. School of Medicine.

A medical examiner for the Federal Aviation Administration and a staff physician for the Marion County Department of Public Welfare, Dr. Rafalski was a member of the board of trustees for the Indiana Society of Internal Medicine. A member of the Marion County Medical Society, he was also a member of the American Medical Association.

Arthur W. Records, M.D.

Dr. Arthur W. Records, 77, a Franklin physician for 52 years, died at his home May 31.

A graduate of the Ohio State University College of Homeopathic Medicine, Dr. Records became a member of the 50-Year Club in 1971 and became a Senior Member of the Indiana State Medical Association in 1968.

He was a member of the Johnson County Medical Society and served as secretary in 1922 and 1952 and as president in 1957. He was also a member of the American Medical Association.

Lester Renbarger, M.D.

Dr. Lester Renbarger, Marion, died April 2 at Marion General Hospital.

A past president of the Indiana Academy of Family Physicians, Dr. Renbarger had practiced medicine in Marion since 1937, except for four years of service with the Army during World War II. He served as Grant County Health Officer from 1967 until 1971.

After graduation from the Indiana University School of Medicine, he interned at Memorial Hospital, South Bend and had a residency in pediatrics at Massachusetts Memorial Hospital, Boston.

A past president of the Grant County Medical Society, Dr. Renbarger was also a member of the American Medical Association. From 1968 to 1971, Dr. Renbarger served on the ISMA Commission on Legislation and was serving on the Constitution and Bylaws Commission at the time of his death.

Dean King Stinson, M.D.

Dr. Dean K. Stinson, who retired in 1972 after practicing medicine in Rochester for 42 years, died April 20 in Woodlawn Hospital.

From 1934 to 1956 he served as Fulton County Coroner and also was county health officer at the time of his death, having served in that post since 1966.

A 1929 graduate of the Indiana University School of Medicine, Dr. Stinson interned at St. Vincent Hospital, Indianapolis.

Dr. Stinson had served as president and secretary of the Fulton County Medical Society and as a delegate to the annual meeting of the Indiana State Medical Association from 1960 until his retirement. He was a member of the American Medical Association.

Ray Gene Tharpe, M.D.

Dr. Ray Tharpe, Indianapolis surgeon, died in Methodist Hospital on April 14. He was 68.

A Navy veteran of World War II, he was a graduate of the Indiana University School of Medicine and interned at St. Vincent Hospital.

Dr. Tharpe had served as secretary of the Marion County Medical Society and as delegate to the annual meeting of the Indiana State Medical Association in 1962, 1963 and 1964. He served on the Convention Arrangements Commission in 1960 and as vice chairman in 1962.

He was also a member of the American Medical Association.

From THE JOURNAL 50 Years Ago

By isolation I do not mean to remove the tuberculous afflicted from the haunts of man, but I do mean that until they have become educated in the care of themselves and others they should have some barrier or restraint placed about them that others may not become infected by association with them, and hospitalization for the advanced cases is almost imperative if we ever expect to control the spread of tuberculosis . . . .

A few months ago I was called to see another girl, only one of the many in like condition, and . . . oh, how badly she wanted to get well! She knew what was ailing her and had been examined by one of the leading tuberculosis diagnosticians of the state. . . . The cards were stacked against her. Her parents were ignorant and dirty. The state tuberculosis hospital was full and she could not purchase a place in another. Before her people could be educated to care for her she was dead, and yet she was only one of many under similar conditions. If the sacrifice of her life and others like her's would awaken the conscience of the community, that these girls and boys, who should be our greatest assets, could be saved, then they would not have died in vain. Here was a young girl in the very dawn of young womanhood sacrificed for the want of proper care, hospitalization, or a place where she could have been given the essential things she didn't get and which should have been hers as her heritage in this glorious country of ours, a country of plenty, the richest on earth, but yet allows her greatest assets to die when they could so easily be saved; and yet they call us a Christian nation because we save our hogs and let our boys and girls be sacrificed to a preventable and a curable disease.

Indiana needs more hospital beds to save her tuberculous citizens and to save others from becoming tuberculous. . . . F. A. Priest, M.D., Marion, "Tuberculosis, Its Diagnosis and Care," **JISMA**, July 1924.

Association News

EXECUTIVE COMMITTEE

Dr. Donald M. Kerr called the meeting to order at the Headquarters Building at 2:00 p.m. on April 20.

Roll call showed the following: Dr. Kerr-present, Dr. William Clark-present, Dr. Joe Dukes-absent, Dr. Gilbert Wilhelmus-absent, Dr. Vincent J. Santare-present, Dr. Hugh K. Thatcher, Jr.-present, Dr. Arvine G. Popplewell-present, Dr. Frank B. Ramsey-present, James A. Waggener-present.

THE MINUTES OF THE MEETING held March 12, 1974, were approved upon motion of Dr. Thatcher seconded by Dr. Clark.

The Membership Report was reviewed and accepted by consent.

RENEWAL OF THE BLUE CROSS-BLUE SHIELD coverage for headquarters staff was approved by motion of Dr. Thatcher and seconded by Dr. Santare.

THE QUESTION OF REUPHOLSTERING some of the chairs in the Board Room and other meeting rooms was referred, by consent, to the Board of Trustees.

UPON MOTION OF DR. THATCHER SECONDED BY DR. CLARK, THE SECRETARY WAS GIVEN AUTHORIZATION TO MICROFILM membership records of the Association. In discussing the microfilming of the transactions of the Association, it was suggested the secretary determine if *The Journal* was currently being microfilmed in Michigan.

THE OFFER OF THE FEDERAL GOVERNMENT TO PROVIDE FUNDS for the carrying on of the assessment program was reviewed and, upon motion of Dr. Thatcher seconded by Dr. Clark, this is to be presented to the Board of Trustees with a strong recommendation from the Executive Committee that the Board permit filing of an application for these funds.

THE TREASURER'S REPORT was given by Dr. Thatcher, and was approved upon motion of Dr. Thatcher seconded by Dr. Santare.

DR. THATCHER THEN REPORTED ON THE BUILDING COMMITTEE ACTIVITIES and asked for permission to employ an architect to get plans under way. By consent, this was referred to the Board of Trustees.

MEMBERSHIP REPORT:

ISMA	**1974**	**1973**	**Increase Over 3/31/73**
Full dues paying	3845	3859	(-14)
Residents	72	50	22
Exempt	513	497	16
TOTAL	4430	4406	24
AMA			
Full dues paying	3554	3567	(-13)
Residents	70	37	33
Exempt	513	497	16
TOTAL	4137	4101	36
Paid ISMA — Not AMA			**Decrease Paying AMA**
Full dues paying	291	292	(-1)
Residents	2	13	(-11)
TOTAL	293	305	(-12)

ORGANIZATION MATTERS

A LETTER FROM THE ISMA LEGAL COUNSEL concerning the Vanderburgh County delegation strength was read for the information of the Committee.

THE PURCHASE OF BLAZERS for the ISMA delegation to the American Medical Association was discussed and referred to the members of the delegation.

A LETTER FROM STATE REPRESENTATIVE ROBERT L. JONES, JR., was read for the information of the Committee.

A COMMUNICATION FROM THE AMERICAN MEDICAL ASSOCIATION seeking recommendation of names of doctors to serve on various FDA Advisory Committees was taken as a matter of information.

A LETTER CONCERNING THE INDIANA STATE MEDICAL ASSOCIATION REPRESENTATIVE to the United States Pharmacopeial Convention was read. Upon motion of Dr. Popplewell seconded by Dr. Clark, it was agreed to rename Dr. S. O. Waife.

A LETTER FROM STANFORD UNIVERSITY SEEKING USE OF THE MAILING LIST was approved by consent.

A LETTER FROM THE STATE BOARD OF HEALTH REGARDING EMERGENCY MEDICAL SERVICES was approved by consent.

MATERIAL WAS DISTRIBUTED FROM DR. MAURICE GLOCK, a member of the State Welfare Advisory Committee gave a report and distributed some materials to the committee. Upon reviewing the material, Dr. Santare moved that the Secretary express the appreciation of the Committee for Dr. Glock's work.

REQUEST FOR USE OF THE MAILING LIST BY INTERCEPT INTERNATIONAL was approved on motion of Dr. Thatcher seconded by Dr. Clark.

A NOTE THAT TERMS OF THE FOLLOWING DOCTORS WERE EXPIRING on various state committees, that of Dr. John Miller on the T.B. Council, Dr. James Benz on the Forensic Sciences Commission, Dr. Edgar C. Stuntz, Division of Alcoholism, and Dr. Sanford Snyderman, Hearing Aid Dealers Advisory Council; by consent, the Committee suggested that all these men be recommended for reappointment.

A RESOLUTION ADOPTED BY JEFFERSON-SWITZERLAND COMPREHENSIVE PLANNING COUNCIL was reviewed for the information of the Committee.

REQUEST FOR THE ASSOCIATION TO MAKE A CONTRIBUTION TO BROTHERHOOD WEEK sponsored by Christians and Jews was turned down by consent.

A LETTER FROM THE AMERICAN PUBLIC HEALTH ASSOCIATION concerning service awards to be made by that organization was reviewed and, upon motion of Dr. Thatcher and seconded by Dr. Santare, the name of Dr. A. C. Offutt was to be submitted for the Sedgwick Memorial Medal.

THE WILL OF MYRTLE LYNN OF PERU, leaving the balance of her estate to the Indiana State Medical Association, was accepted as a matter of information.

A LETTER FROM THE STATE BOARD OF HEALTH concerning T.B. testing was taken as a matter of informa-

tion and recommended that this be reproduced in *The Journal.*

A LETTER ADDRESSED TO ERNEST B. HOWARD, M.D., executive vice president of the American Medical Association, from the Clark County Medical Society was read for the information of the Committee.

A LETTER FROM THE MARION COUNTY MEDICAL SOCIETY addressed to Dr. John Butler, their Trustee, urging that the ISMA file for a Support Center Grant for PSRO, was read for the information of the Committee and referred to the Board of Trustees.

A LETTER FROM THE WOMAN'S AUXILIARY to the Student American Medical Association seeking a contribution from this Association was read, the Secretary was instructed to inform them that our contributions would be made only to an Indiana organization.

SEVERAL PROPOSALS for 1975 travel programs sponsored by the Association were presented and, by consent, this was referred to Dr. Wilhelmus, chairman of the Travel Committee.

THE SECRETARY REPORTED ON A RECENT MEETING IN CHICAGO, which was an informational session urging state medical societies to file for a federal grant to obtain a PSRO Support Center, and, upon motion of Dr. Thatcher and taken by consent, this was referred to the Board of Trustees with the request that the Board approve the filing of such an application.

THE JOURNAL. Dr. Ramsey gave a brief report of the activities of *The Journal,* which was taken by consent.

THE SECRETARY REPORTED THAT HE HAD RECEIVED A STATEMENT FOR LEGAL SERVICES from a member of the Association in the amount of $1,131.90. Inasmuch as this suit had not even been brought to trial, the secretary was instructed to inform the physician that he was rapidly approaching the limit for which the Association could reimburse him for legal counsel. It was suggested that this might be discussed with the Board of Trustees.

A LETTER FROM THE ASSOCIATION'S LEGAL COUNSEL stating that a recent decision in the statute of limitations case by the Court of Appeals had been sent to the Indiana Supreme Court.

NEW BUSINESS

THE SECRETARY PRESENTED A PLAN FOR REVISING AND UPDATING THE TELEPHONE System in the Headquarters Building and presented a recommendation from the telephone company. The contract for signature was approved upon motion of Dr. Thatcher seconded by Dr. Clark.

THE COMMITTEE THEN DISCUSSED THE FORTHCOMING HEARING OF SENATOR TALMADGE and it was suggested that the Association ask permission to have a representative of the Association to personally appear before this Committee on May 8 or 9.

A BRIEF REPORT WAS GIVEN concerning plans for the 1974 125th Annual Convention.

THE SECRETARY INFORMED THE COMMITTEE THAT THE AMERICAN MEDICAL ASSOCIATION was planning to start AMA-CAP which would permit the Association to tie in with the AMA computers for the maintenance of membership records, for searching out information regarding physicians and the preparation of mailing list. The secretary informed the Committee he had not had time to study this proposal in detail, and besides it was subject to the approval of the Board of Trustees of the American Medical Association. Upon motion of Dr. Clark seconded by Dr. Popplewell, the Secretary was instructed to make an in-depth presentation of this proposal.

DR. THATCHER SUGGESTED THAT THE ASSOCIATION WRITE A LETTER TO THE AMA URGING A PUBLICITY CAMPAIGN TO EXPLAIN THE COST OF MEDICAL CARE. Dr. Thatcher is to talk to Dr. Wood, and Mr. Waggener will be instructed on what steps are to be taken in this regard.

THERE BEING NO FURTHER BUSINESS, the meeting adjourned to meet again at 2:00 p.m. on June 8 or June 15, depending on the availability of the delegates handbook for the AMA meeting in June. ◄

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PHYSICIANS OPENINGS IN INDIANA REHABILITATION SERVICES

The Indiana Rehabilitation Services has openings for physicians in its various divisions. Interested persons should contact Dr. Walter E. Deacon, Room #1028 Illinois Building, Indianapolis, Indiana. Telephone (317) 633-6942.

IMMEDIATE OPENING for Ob-Gyn and Internal Medicine specialties to establish successful practice with 14-man multi-specialty group. Excellent group benefits; pension plan; modern clinic facilities; progressive community with excellent educational system including two colleges; city population 35,000; good recreational facilities; each specialty must be board eligible or certified. Contact: Business Manager, The Manitowac Clinic, 601 Reed Avenue, Manitowac, Wisconsin 54220.

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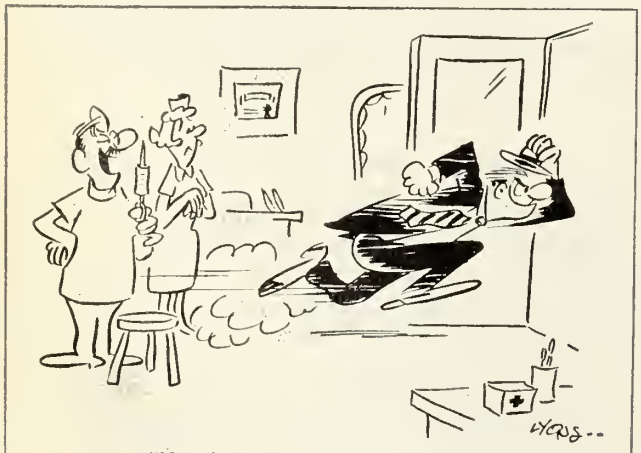
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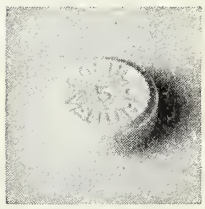
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For further information on this subject, the following references are provided:

1. Henry BW, *et al: Dis Nerv Syst 30*:675-679, Oct 1969.
2. Hollister LE, *et al: Arch Gen Psychiatry 24*:273-278, Mar 1971.
3. Claghorn J: *Psychosomatics 11*:438-441, Sept-Oct 1970.



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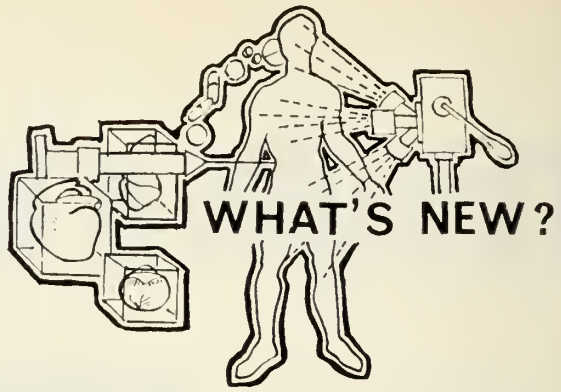
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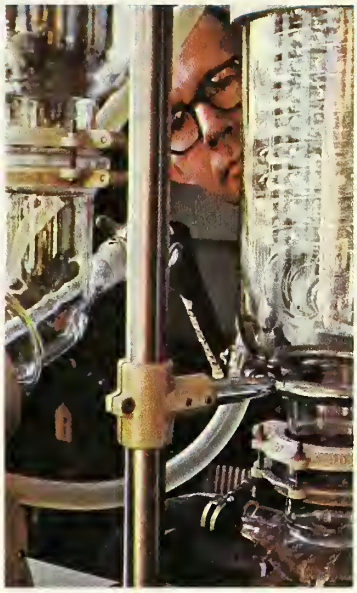
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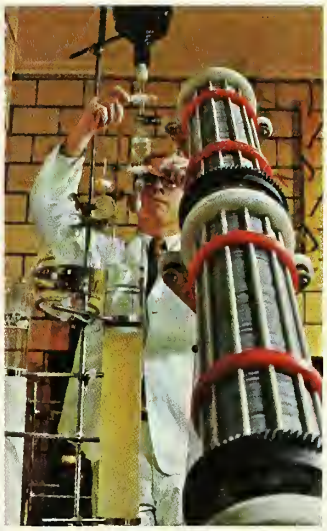
















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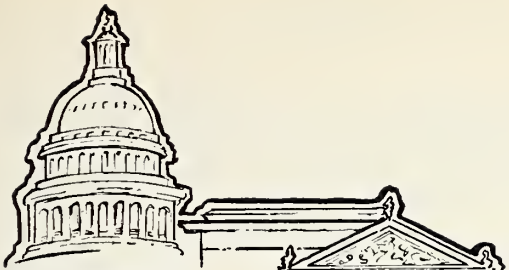
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MONTH IN WASHINGTON

This summary of what is happening in Washington is prepared by AMA's Capitol office and air-mailed to The Journal on the first of each month preceding month of issue.

The humdrum hearings on national health insurance (NHI) before the House Ways and Means Committee got something of a lift when the long-absent chairman, Wilbur D. Mills, (D-Ark.), unexpectedly showed up on Friday in mid-June and announced that whatever bill his committee approves undoubtedly would not look like any single bill presently under consideration.

This pronouncement from the august chairman immediately gave rise to the belief that closed door talks may be going on among committee members in an effort to hack out a compromise bill that could secure congressional enactment this year.

But the startling lack of interest evident in the House Ways and Means Committee hearings—only two or three members attending each hearing and Chairman Mills showing up for just the second time in months—and the indefinite postponement of Senate Finance Committee hearings would seem to say the Congress is not "busting its britches" to pass a NHI bill this year.

Mills said his own plan (Mills-Kennedy) "doesn't do everything I would like it to do." He said, however, he believes the method of reimbursing physicians under Mills-Kennedy is better than under Medicare. It would eliminate the apparent discrimination between the city physician and the rural physician, Mills believes.

He declared his primary concern is that the poor receive at least as good medical services as the rest of the people. Referring to the compromise with Kennedy, he said, "We were trying to lay before the public a program we thought had a chance to pass." He said he wanted to avoid a bill that "would provide nothing more than catastrophic," which would cover only 5% of the need. The compromise is subject to further compromise, Mills said. Catastrophic is the roof, and "we need the floor and walls along with the roof."

Mills said his intent with the Mills-Kennedy compromise NHI bill was not to exceed the cost of the Administration's "CHIP" plan and to come up with a different method of financing. He said the bill was introduced to present an alternative to the Administration plan for discussion and comment.

Here are selected sample bits of testimony from the many organizations which have trooped to Washington to have their say about NHI:

■ The American Public Health Association urged more consumer policy input than provided in any of the major NHI bills before the committee and more preventive services benefits. APHA President C. Ardin Miller, M.D., said the major measures for the most part provide insufficient benefits and controls.

■ The American Association of Medical Clinics supported maintenance of the free enterprise system of health care, and said funding should be from mandated employer plans and general tax funds for the poor and medically indigent.

■ The Colorado Health and Environment Council witness discussed the Colorado Community-Cooperative-Decentralized plan which emphasizes preventive medicine and home health care. The importance of the physician's office as a basic health care facility was stressed.

■ The National Association of Social Workers favored the Kennedy-Griffiths, Health Security Act provisions.

■ The American Academy of Family Physicians told the House Ways and Means Committee any NHI bill must provide that family physicians receive the same fee as other specialists when providing the same service. Family physicians should not be treated as "second class members of the health care delivery team," said James Price, M.D., academy president.

Wealthier people should pay a greater portion of the cost for catastrophic coverage, as provided in the American Medical Association's Medicredit plan, he told the committee.

"We are skeptical as to just how all-encompassing a program can be effectively administered by the federal government and would strongly urge that, insofar as possible, continued reliance be placed on the expertise which has been developed by the private insurance industry," he said.

Dr. Price opposed a provision of the Mills-Kennedy bill (Medicare for all) regarding payment for services by specialists, saying that the determination of which physicians should not be providing specific serv-

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Terms expire December 31, 1975:

Delegates: Patrick J. V. Corcoran, Evansville; Lowell H. Steen, Ham-mond.

Alternates: Thomas C. Tyrrell, Hammand; Peter R. Petrich, Attica.

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1.	Albert S. Ritz, Evansville	John H. Barrow, Dale	
2.	Jack L. Shanklin, Vincennes	J. S. Brown, Carlisle	
3.	Claude J. Meyer, Jeffersonville	J. L. Millan, Jeffersonville	Sept. 14-15, Clarksville
4.	A. A. Daftary, Batesville	Lanny Capeland, Osgaad	Ripley Caunty
5.	Paul Humphrey, Terre Haute	Fred Dierdarf, Terre Haute	
6.	Davis W. Ellis, Jr., Rushville	Clarence G. Clarksan, Richmond	
7.	Ray D. Miller, Martinsville	M. O. Scamaharn, Pittsbaro	
8.	Eugene M. Gillum, Partland	James S. Fitzpatrick, Partland	Partland
9.	Milton W. Erdel, Frankfort	Harry T. Staut, Frankfort	Rensselaer
10.	Maria D. Mansueto, Munster	James R. Brown, Valparaisa	Sept. 25, Valparaiso
11.	Joseph S. Bean, Logansport	Fred Paehler, La Fontaine	Sept. 18, Logansport
12.	Franklin A. Bryan, Fort Wayne	Karl R. Schlademan, Fort Wayne	Sept. 19, 1974, Fort Wayne
13.	Jack Hannah, Elkhart	David L. Spalding, Mishawaka	Sept. 11, 1974, Elkhart

ices should be left to their peers rather than the Social Security Administration.

■ Another witness, Donald Schiff, M.D., of the American Academy of Pediatrics, said "we must build upon the strengths of our present medical care system, taking special pains to retain the currently productive programs such as Crippled Children's, Maternal and Child Health, and Children and Youth."

Preventive health services should encompass the entire pediatric age scale to 21 years, said Dr. Schiff. Deductibles and co-insurance should not be used for preventive health care for children or pregnant women, he asserted. Comprehensive child health care should be a spelled-out benefit, and increased funding of psychological services is necessary, according to the physician. He urged creation of a cabinet post, Secretary of Health.

■ Ned Parish, President of the National Association of Blue Shield Plans, said the concept of a totally tax-supported and government administered national health program is "a solution for a problem which no longer exists."

"We have built in America a private system which extends to the vast majority of the population and serves most of them quite well," he said.

Declaring that the public does not support radical restructuring of the health system or its financing, Parish said federal action is clearly necessary that would strengthen private coverage and at the same time eliminate problems that "can never be resolved without the active participation of government."

He called for:

— Federal financing of coverage for the poor and medically indigent.

— Catastrophic coverage, not federally financed, tied to a program of basic benefits.

— Regulation of carriers with respect to covered benefits and solvency.

— Minimum standards for coverage.

— Free choice and maximum participation by the private sector.

■ In other testimony, the U.S. Chamber of Commerce urged approval of its own mandated-coverage NHI plan as "realistic, reasonable and affordable." The Mills-Kennedy plan would lead to "federal domination of the health program" and impose excessive new payroll taxes, the Chamber said. The Administration's "CHIP" plan would significantly increase costs to small and medium sized businesses and the AMA's Medicredit plan is not comprehensive enough, according to the Chamber.

■ Pharmaceutical Manufacturers Association President C. Joseph Stetler said the Mills-Kennedy bill provision for a restrictive national formulary for outpatient drugs would distort prescribing decisions. The PMA is most concerned with the proposed price controls on drugs, Stetler testified. This would force a diversion of sales from research-based firms to the non-researching sector, he said.

The National Protestant-Catholic Hospital Association said the Mills-Kennedy bill does not adequately ensure that hospitals will be reimbursed for their costs and could force non-profit hospitals "into a hand-to-mouth existence." Voluntary donations would cease, the Association warned.

■ Consumer Federation of America—favored the labor-backed Health Security bill, and argued that sole reliance on payroll tax as in Mills-Kennedy is regressive. The Federation indicated it would prefer a program financed solely out of general revenues.

— National Cancer Foundation—all bills fall short of providing adequate catastrophic coverage.

— The National Association for Mental Health—legislation should emphasize outpatient services and stimulate Comprehensive Community Mental Health Centers.

— National Kidney Foundation—"We have major trepidation about the ability of existing administrative machinery to manage a NHI program of far greater dimensions and scope than the end-stage renal disease program."

And so the testimony goes—mind boggling from the standpoint of volume to the two or three members of the Ways and Means Committee that must listen patiently all day long every Friday until mid-July.

Named to USUHS Board of Regents

P. O'B Montgomery, M.D., Dallas, has been nominated by the President to the Board of Regents of the new Uniformed Services University of the Health Sciences.

Dr. Montgomery, a professor of pathology at the University of Texas Southwestern Medical School, was named to serve the remainder of the four-year term of Anthony R. Curreri, M.D., recently appointed president of the new school. The nomination goes to the Senate for approval.

Other members of the board of the new school include Malcolm Todd, M.D., president of the AMA; Charles E. Odegaard, M.D., president of the University of Washington; Joseph D. Matarazzo, M.D., chairman of medical psychology, University of Oregon Medical School; Durward G. Hall, M.D., a recently retired Congressman from Missouri; Alfred A. Marquez, M.D., of San Francisco, and Lt. Gen. Leonard D. Heaton, MC, USA (Ret.).

Tentative Changes in Tax Laws

Working on a sweeping tax reform bill, the House

Continued

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Ways and Means Committee tentatively has decided to change the tax laws affecting medical deductions and business expenses that would affect consumers and physicians.

Apparently with an eye on the possibility of a national health insurance program being enacted, the Committee voted to remove the present deduction for one half the amount an individual pays for his health insurance premium (up to $150), and to increase the present 3% of income floor applicable to medical expenses to 5%. The 1% of income test for drug costs would be abandoned, with the drug expenses coming under the 5% medical expenses category. Only prescription drugs would be covered.

In addition, the Committee decided to do away generally with the sick-pay exclusion under which a tax break is provided employees who are paid while sick beyond a certain length of time.

In the business field, the Committee closed the door on business expenses resulting from attending conventions overseas unless there is an overriding reason for holding the meeting abroad. Not counted would be Puerto Rico, Hawaii, and American possessions. All cruise ship business expenses would not be acceptable, if the Committee's decision should be enacted by Congress.

Three to Five Years Start-Up Time for HMOs in Florida

Florida's experience is that the average start-up time for a full-service Health Maintenance Organization (HMO) is three to five years, Tampa physician-legislator Richard S. Hodes, M.D., has told the House Ways and Means Committee.

Testifying at the Committee's national health insurance hearings, Dr. Hodes headed a delegation of the National Legislative Conference, an organization of state legislators.

Dr. Hodes outlined Florida's recent activities in health services, noting that unless federal support is continued for such programs as Hill-Burton, Comprehensive Health Planning and Regional Medical Programs, a state's health program might be further snarled by adding national health insurance.

Dr. Hodes is chairman of the Florida House of Representatives Committee on Health and Rehabilitative Services, and heads the Human Resources Task Force of the National Legislative Conference's Intergovernmental Relations Committee.

Florida has had an HMO licensing act for over two years, he noted, but thus far, only five are licensed.

Careful licensing to ensure both the quality care and financial soundness has protected the patient, "but the experience has taught us a hard lesson," he said.

"This lesson is that the average start-up time for a full service HMO is from three to five years, and that the popular conception of HMOs as a panacea for our ills is unfounded," said Dr. Hodes.

"In fact, HMOs have a somewhat limited utility since the institution is totally dependent on resources within the community," he said.

Rural HMOs will require more time and planning before they can become one of the remedies for rural health needs, he added. ◄



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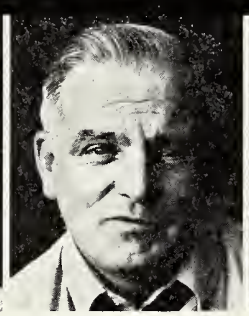
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MONTHLY REPORT—JUNE 1974

Disease	June 1974	May 1974	Apr. 1974	June 1973	June 1972
Animal Bites	1637	1019	968	1849	1732
Chickenpox	389	668	517	536	436
Conjunctivitis	251	216	155	252	260
Diphtheria	0	0	0	0	0
Dysentery, Unspecified	86	65	99	33	38
Gonorrhea	1532	910	918	1291	1114
Impetigo	157	122	91	125	159
Infectious Hepatitis	76	82	57	64	50
Infectious Mononucleosis	42	73	102	55	73
Influenza	2214	2561	3717	1433	565
Measles					
Rubeola	31	41	44	60	115
Rubella	65	54	31	69	68
Meningococcic Meningitis	0	1	4	2	1
Meningitis, Other	3	2	4	2	9
Mumps	142	137	94	82	82
Pertussis (Whooping Cough)	6	4	1	2	4
Pneumonia	509	392	636	467	382
Poliomyelitis	0	0	0	0	0
Streptococcal Infections	1583	1595	1697	1276	903
Syphilis					
Primary & Secondary	9	15	21	28	13
All Other Syphilis	144	103	120	127	157
Tinea Capitis	12	18	14	8	3
Tuberculosis (Active)	91	41	42	80	59



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The Role of the Detail Man

Opinion & Dialogue

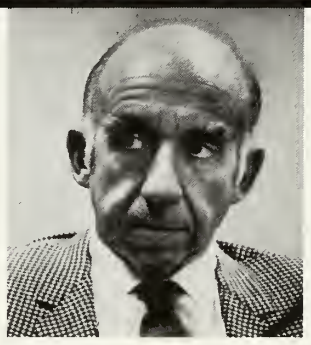


Dr. Willard Gobbell
Family Physician
Encino, California

"I may be prejudiced, but I am very much in favor of the detail men I meet. Most of them are knowledgeable about the drugs they promote and can be a great help in acquainting me with new medication."

Family Physician's Perception

I think that most general practitioners in this area feel as I do about the detail man. Over the years I have gotten to know most of the men who visit me regularly and they in turn have become aware of my particular interests and the nature of my practice. They, therefore, limit their discussion as much as possible to the areas of interest to me. Since I usually see the same representative again in future visits, it is in his best interest to supply me with the most honest, factual, as well as up-to-date inforrnation about his products.



Dr. Jeremiah Stamler
Chairman
Department of Community Health and Preventive Medicine, and Dingman Professor of Cardiology
Northwestern University Medical School

"In the total picture of dealing with health problems in this country there is a potential for detail men to play a meaningful role."

The Positive Influence

My contact with representatives and salesmen of the pharmaceutical industry is the type of contact that people in a medical center, research people, and academic people have and that's in all likelihoo on a somewhat different level from that of the practicing physician.

Let me touch on how I personally perceive the role of the sales representative. These men reach large numbers of health professionals. Thus they could be—and at times actually are—disseminators of useful information. They could consistently serve a real educational function in their ability to discuss their products.

At present they do distribute printed material, brochures and pamphlets—some of it scientifically sound and therefore truly useful—as well as some excellent films produced by the pharmaceutical industry. When they function in this

; He a Source of Information?

Yes, with certain reservations. he average sales representative as a great fund of information bout the drug products he is re-ponsible for. He is usually able to nswer most questions fully and ntelligently. He can also supply eprints of articles that contain a reat deal of information. Here, oo, I exercise some caution. I usu-lly accept most of the statements nd opinions that I find in the apers and studies which come rom the larger teaching facilities. goes without saying that a physi-ian should also rely on other ources for his information on harmacology.

raining of Sales Representatives

Ideally, a candidate for the osition as a sales representative f a pharmaceutical company hould be a graduate pharmacist ho has a questioning mind. I don't hink this is possible in every case, nd so it becomes the responsibility of the pharmaceutical company to train these individuals comprehensively. It is of very great importance that the detail man's knowledge of the product he represents be constantly reviewed as well as updated. This phase of the sales representative's education should be a major responsibility of the medical department of the pharmaceutical company.

I am certain that most of these companies take special care to give their detail men a great deal of information about the products they produce—information about indications, contraindications, side effects and precautions. Yet, although most of the detail men are well informed, some, unfortunately, are not. It might be helpful if sales representatives were reassessed every few years to determine whether or not they are able to fulfill their important function. Incidentally, I feel the same way about periodic assessments of everyone in the health care field, whether they be general practitioners, surgeons or salesmen.

Value of Sampling

I personally am in favor of limited sampling. I do not use sampling in order to perform clinical testing of a drug. I feel that drug testing should rightly be left to the pharmacology researcher and to the large teaching institutions where such testing can be done in a controlled environment.

I do not use samples as a "starter dose" for my patients. I do, however, find samples of drugs to be of value in that they permit me to see what the particular medication looks like. I get to see the various forms of the particular medication at first hand, and if it is in a liquid form I take the time to taste it. In that way I am able to give my patients more complete information about the particular medications that I prescribe for them.

---

apacity they are indeed useful; articularly in the fact that they isseminate broadly based educa-onal material and serve not just s "pushers" of their drugs.

he Other Side of the Coin

Obviously, the pharmaceuti-al companies are not producing all his material as a labor of love—ey are in the business of selling roducts for profit. In this regard he ambitious and improperly moti-ated sales representative can xert a negative influence on the racticing physician, both by pre-enting a one-sided picture of his roduct, and by encouraging the ractitioner to depend too heavily n drugs for his total therapy. In hese ways, the salesman has often istorted objective reality and ndermined his potential role as an ducator.

he Industry Responsibility

Since the detail man must be n information resource as well as representative of his particular harmaceutical company, he hould be carefully selected and thoroughly trained. That training, perforce, must be an ongoing one. There must be a continuing battle within and with the pharmaceutical industry for high quality not only in the selection and training of its sales representatives, but also in the development of all of its promotional and educational material.

The industry must be ready to accept constructive as well as corrective criticism from experts in the field and consumer spokesmen, and be willing to accept independent peer review. The better educated and prepared the salesman is, the more medically accurate his materials, the better off the pharmaceutical industry, health professionals and the public—*i.e.*, the patients—will be.

Physician Responsibility

The practicing physician is in constant need of up-dated information on therapeutics, including drugs. He should and does make use of drug information and answers to specific questions supplied by the pharmaceutical representative. However, that information must not be his main source of continuing education. The practitioner must keep up with what is current by making use of scientific journals, refresher courses, and information received at scientific meetings.

The practicing physician not only has the right, but has the responsibility to demand that the pharmaceutical company and its representatives supply a high level of valid and useful information. I feel certain that if such a high level is demanded by the physician as well as the public, this demand will be met by an alert and concerned pharmaceutical industry.

From my experience, my impression is that sectors of the pharmaceutical industry are indeed ethical. I challenge the industry as a whole to live up to that word in its finest sense.

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The Journal of the INDIANA STATE MEDICAL ASSOCIATION

Volume 67—August 1974—Number 8

Eighteen cases of epidermoid carcinoma of the cervix or vagina, occurring 10 or more years after therapy for cervical carcinoma was administered, have been seen since July 1, 1965. These cases are evaluated and discussed. Although definitive proof is impossible, it is theorized that these tumors are new, ano-genital tract carcinomas. Surgical therapy offered the best results. Reirradiation produced disastrous consequences. Careful follow-up of cancer patients is the key to early discovery.

Carcinoma of the Cervix or Vagina, 10 or More Years after Therapy: Recurrence or New Primary?

HANS E. GEISLER, M.D.
Indianapolis

Introduction

THE modalities used in treating primary carcinoma of the cervix and the results of such therapy have been enumerated repeatedly in the last three decades. In treating recurrent carcinoma of the cervix, a surgical approach has, in general, been favored over reirradiation.[1,2,3]

Recurrences usually become evident within two or three years following completion of primary therapy. Close follow-up during that time has been emphasized. Little has been written concerning either the diagnosis or the treatment of carcinoma of the cervix or vagina appearing 10 or more years after therapy has been completed.

From the Division of Gynecologic Oncology, Department of Obstetrics and Gynecology, St. Vincent Hospital, 2001 W. 86th St., Indianapolis, 46260.

Materials and Methods

In reviewing all cases of carcinoma of the cervix seen by the author from July 1, 1965, through December 31, 1972, 18 patients were found who developed cervical or upper vaginal carcinomas 10 or more years after initial therapy.

The clinical staging of the original cervical carcinoma was known in 14 cases, including 5 in Stage I, 5 in Stage II and 4 in Stage III.

In 7 of the 18 patients, the new carcinoma did not appear until 15 or more years after treatment of the original neoplasm.

All patients in the group had epidermoid carcinomas, both when the initial and the second neoplasm were discovered.

The age at the time of the first diagnosis corresponded to that generally quoted for patients with invasive carcinoma of the cervix.

Vaginal bleeding, leg pain and edema, and an unusual vaginal discharge were the most common symptoms.

Twelve abnormal urograms were found at the time of the second diagnosis. Seven patients had partial ureteral obstruction and five patients had non-function of one kidney.

As far as could be determined, the irradiation therapy in 14 patients had been adequate for the primary disease. Two patients had had simple hysterectomies followed by external irradiation and two patients had had external therapy only.

Eight patients were reirradiated. None did well, with five developing bladder and rectal fistulae. All died of their disease within one year. Two patients refused any therapy. Eight patients underwent an ex-

ploratory laparotomy and, in four of these, a definitive surgical procedure was carried out. In one case, this consisted of a radical abdominal hysterectomy and vaginectomy. In three patients, pelvic exenterations were performed, two anterior and one total. In the other four patients, evidence of unresectability was found at the time of surgery. These patients were then treated with chemotherapy. Currently, in these and other patients with far advanced, unresectable, cervical carcinoma, a regimen of high dose methotrexate therapy with leucovorin rescue is being evaluated.

Discussion and Conclusions

Most cervical carcinomas, if they recur, will recur within the first few years following therapy. With modern techniques of radiotherapy and surgery, few of these recurrences should be located centrally.[4] Van Herick and his group from the Mayo Clinic recently reported 16 cases of late recurrence in cervical carcinoma patients.[5] Although they seemed to feel that these tumors could be recurrences, it is our opinion that a squamous cell carcinoma appearing in the cervix or upper vaginal tract, 10 or more years post treatment, is more likely to represent a new primary neoplasm. Certainly, the same carcinogenic stimulus which led to the first carcinoma may still be present. Also, this concept is compatible both with the theory of multicentric sites of origin of epidermoid carcinoma in the genital tract,[6] and with the possible development of radiation-induced carcinomas.

The only tool available to the gynecologist to ensure early recognition of such a new, potentially lethal problem in a previously treated cancer patient is continuous, close follow-up. A program of annual or semi-annual radiographic examinations of the urinary tract might have been helpful in evaluating our group of patients, but careful and repeated pelvic and cytologic examinations remain the cornerstones of early recognition of carcinoma in the upper vaginal tract and cervix.

When a new carcinoma is discovered in a previously radiated area, the malignancy should be resected, if possible. Even if surgical removal is not feasible, exploratory laparotomy will allow determination of the extent of the disease, so that the results of chemotherapy or any other therapy can be more carefully directed to the proper areas, and its results be better assessed.

BIBLIOGRAPHY

1. Brunschwig, A.: Surgical treatment of carcinoma of the cervix, recurrent after irradiation or combination of irradiation and surgery. *Am. J. Roentgenol.* 99:365, 1967.
2. Mattingly, R.F.: Total pelvic evisceration. *Clin. Obstet. Gynecol.* 8:705, 1965.
3. Kiselow, M., Butcher, H.R. Jr., Bricker, E.M.: Results of the radical surgical treatment of advanced pelvic cancer: a fifteen year study. *Ann. Surg.* 166:428, 1967.
4. Munnell, E.W., Bonney, W.A.: Critical points of failure in the therapy of cancer of the cervix. A study of 250 recurrences. *Am. J. Obstet. Gynecol.* 81:521, 1961.
5. Van Herick, M.; Decker, David G.; Lee, Raymond A.; Symmonds, Richard E.: Late recurrence in carcinoma of the cervix. *Am. J. Obstet. Gynecol.* 108:1183, 1970.
6. Marcus, S.L.: Multiple squamous cell carcinomas involving cervix, vagina and vulva; theory of multicentric origin. *Am. J. Obstet. Gynecol.* 80:802, 1960. ◄

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The purpose of this presentation is to discuss colposcopy as an intermediate step between routine gynecological examination and definitive histopathological diagnosis of cervical lesions commonly encountered in the private practice of medicine.

Colposcopy for the Family Physician

THOMAS M. CONLEY, M.D.
Kokomo

COLPOSCOPY is a method of inspecting the vaginal surface of the uterine cervix with an instrument which essentially is a low-power stereoscopic microscope. It has a good illumination system which centers a strong light upon the tissue being examined. A green filter is built into the instrument. Camera and electronic flash-lamp attachments are additional features that make it capable of taking photographs. The lens distance of about 22 cm allows the colposcope to be positioned completely external to the patient. There is no hindrance, therefore, in doing laboratory tests such as taking smears or biopsies from target areas under direct observation.

Tissue areas other than the ectocervix can be inspected with the instrument. Cervical specula have been designed to facilitate seeing into the endocervical canal to variable depths.[10] The colposcope also can be used for inspecting the vaginal mucosa and the vulva.

At a magnification of 10-20X, the tissue observed is seen in detailed patterns. Certain features specifically are looked for by the trained colposcopist: (1) General surface configuration and contour; (2) Color tone; (3) Amount of opacity; (4) Location of the original squamo-columnar junction; (5) Angio-architecture; (6) Variation in inter-capillary distance; (7) Clarity of demarcation in the boundary between lesions and the adjacent normal tissue. (See Kolstad and Stafl,[8] p. 21.)

These patterns can be modified by certain techniques of illumination and/or application of solutions so as to render the tissue more diagnostic. Most useful among these techniques are the following:

(1) Cleansing the surface of the cervix with normal saline solution causes the terminal blood vessels in the stroma to be very evident.

(2) The green filter of the colposcope makes blood vessels appear very dark and it also accentuates certain features of the epithelia.

(3) Application of 3% solution of acetic acid clouds the epithelia so that they become somewhat opaque. This change is characteristically different for columnar as compared to the squamous epithelium, thus contrasting the two tissues. The tufts of columnar epithelium react by swelling; they then resemble small white grapes.

(4) Covering the cervix with Schiller's Solution or with Lugol's Solution does stain, or does not stain, tissue depending upon the sugar content of the areas involved —thus having differential qualities.

These techniques, when combined with the enlargement made possible with the use of the colposcope, result in extremely effective diagnostic procedures.

Repeated clinical observations imprint in the mind of the examiner a storehouse of knowledge of tissue patterns which later can be recognized almost at a glance. He becomes stimulated to do more disciplined study of the cervix in its normal and abnormal manifestations. He not only wants to know "What is it?" but also "Why is it there?" "How did it become what it is?" and "What is likely to happen to it as a lesion if it is not treated?" The vast majority of the cervices routinely examined in private practice are "normal"—that is, they present either the native (original) epithelia and typical stromal blood vessels or they have the "usual" physiological changes that occur during various stages in a woman's life. The trained colposcopist can delineate with no difficulty the normal from the overtly pathological changes. He can recognize tissues that are changed from the normal yet are benign lesions. With increased expertise, he develops an index of suspicion of very early degrees of change which produce certain patterns that appear atypical. The clinician using colposcopy looks for pathology; but he also appreciates well the normal. But most important of all for the general practitioner, there is an inward sense of deep satisfaction in progressively becoming more knowledgeable in these matters.

The common colposcopic findings are:

Physiological Tissue:
Native (original) epithelium and blood vessels

- Ectopy
- Transformation zone with various stages of typical change

Benign Lesions:
- Cervicitis
- Polyps
- Condylomata
- Papilloma
- Inconspicuous nonstaining areas to iodine

Atypical Tissue Pattern:
- Punctation
- Mosaic patterns
- True erosion
- Leukoplakia
- Abnormal blood vessel structures with change in intercapillary spacing

For detailed description and discussion of these various conditions, refer to the excellent monographs and atlases listed in the bibliography.

The problem of nomenclature of cervical lesions, colposcopic patterns and tissue structures has been complicated over the years by the various disciplines coining different words to describe the same entities. Efforts toward clarifying the terminology have been made. An International Symposium on Colposcopic Terminology was held at the clinical meeting of the American Society of Colposcopy and Colpomicroscopy in October 1973, to deal with the difficulty. The results of these efforts will be in print soon.

Cancer of the cervix is believed to start as a small lesion, possibly of only a few cells, and then to develop over a prolonged period of time through various degrees of severity from (1) Mild dysplasia to (2) Moderate dysplasia to (3) Severe dysplasia to (4) Carcinoma in situ to (5) Microcarcinoma to (6) Invasive carcinoma. It has been well documented that cervical cancer invariably arises within the transformation zone at or near the squamo-columnar junction. Richart[11] has postulated a theoretical construct based on clone behavior as to why this site should be more favorable for neoplastic changes than locations elsewhere on the cervix.

It is believed that certain cells in the cervix are modified in some way at particular times in a woman's life so that these cells act differently and may become neoplastic later in life. These changes in the cervix are apt to occur at puberty, and increasingly so if there has been early onset of promiscuous sexual activity. The cervix appears to be more vulnerable to these marked changes also at the first pregnancy, especially in the very young woman. This would imply that routine cancer detection examinations should be done at a much earlier age in life if the patient has been sexually active during her teenage years. A correlative trend in therapy is to treat early cervical intraepithelial neoplasia in young women conservatively.[14]

Much that has been written in the last few decades concerns a comparison of diagnostic methods for the earliest definitive diagnosis of cervical pathology: i.e., cytology vs. colposcopy, punch biopsy vs. conization, etc. Most authors agree that all diagnostic methods available should be utilized as indicated for the individual case, recognizing that each method taken by itself has its particular advantages and limitations. For instance, Navratil[9] has reported an increased degree of diagnostic accuracy in detecting preclinical carcinoma from 87% by cytology alone and 79.1% by colposcopy alone to 98.8% when both are used simultaneously. Cytology is a laboratory procedure which indicates that pathology exists somewhere; colposcopy is a clinical examination which helps to localize the lesion and indicate the extent of the pathology. Neither is infallible. The use of both methods simultaneously would be the ideal procedure, for the failures of one method would counter the failures of the other. They are not in competition but are complementary procedures. The patient will be ensured the maximum security which can be offered her by contemporary screening possibilities when the combined methods are made available to her by her family physician.

It is believed that the minute changes in the epithelium and blood vessels which occur in early dysplasia can be detected with the colposcope almost with the same accuracy as the more advanced lesions. Colposcopically guided scrapings can be made for cytologic and/or genetic studies. Direct biopsies can be taken from the exact area(s) which clinically appear to be the most advanced pathology. When conization is indicated, the clinician has more insight as to the extent (narrow or wide) and as to the depth (shallow or deep) of the surgical procedure. The surgeon can mark or tag for the pathologist the location which on colposcopic examination seemed to be the most likely site of atypism. This area, when sectioned, may reveal the maximum pathology and thus make unnecessary the need for expensive serial sections of the entire coned specimen. Colposcopy also can aid in the study of the histogenesis of cervical neoplasia. The atypical area(s) can be observed clinically by repeated examinations over long periods of time. Any progression or regression can be followed.[5]

It is most important to realize that during a woman's life-span the squamo-columnar junction has a wide variation as to location on the surface of the cervix or within the endocervical canal.[3,6] Also, there is a process of change in the ectopically placed columnar epithelium so that a modified form of squamous epithelium eventually covers variable areas of the cervix.[2] This process has been called by different terms and the histogenesis has been variously described. Bolton[1] stressed the important fact that this transformation zone is not static but is a very dynamic area. Most of the tissue patterns, both normal and atypical, are located in this zone for most of a woman's life-span. Since the squamo-columnar junction and any transformation zone activity can easily be observed on the ecto-

cervix in women of the childbearing age, any lesion(s) present will be within direct view. The squamo-columnar junction recedes high up into the endocervical canal in post-menopausal women; any lesion present most probably will not be seen. In these patients, the colposcopic examination can affirm that the squamo-columnar junction is high within the endocervical canal. This indicates the need for thorough endocervical curettement or that the cone be extended deep toward the internal os.

Conization is not without expense, morbidity and operative risk.

Many investigative reports have been made as to the economics, the safety and the efficiency of colposcopically guided spot biopsies prior to conization. In many instances maximum pathology diagnosis is made by biopsy alone. The cost of good patient care often can be reduced by more selectively determining which cases need hospitalization for diagnostic conization. Colposcopy has virtually eliminated the need for conization in the pregnant patient with an abnormal Pap test.[13] Peripheral extension of atypical changes beyond the cone specimen is less likely to be missed if the cervic is colposcoped beforehand. Even a relatively large cone specimen often will not remove all the involved tissue when the extent of the lesion has not been accurately determined prior to surgery.

Colposcopy, however, does not always reveal dysplasia or preclinical cervical cancer when such pathology has been found later on tissue histologically examined. Kolstad[7] states that the reasons for these failures have been due to: (1) Purely endocervical lesions that could not be seen; (2) Small lesions developing deep in the cervical clefts and folds and thus hidden from view; (3) Lesions in an old transformation zone now covered by normal-appearing epithelium; (4) Complex transformation zone modified by concomitant inflammation, especially trichomoniasis.

There are many situations in which women should have the benefit of not only the Pap smear but also a competent colposcopic examination at their gynecological visit: (1) All women with suspicious (Class III) or more advanced Pap smears. This is particularly true for the pregnant or the very young patient. (2) Patients who have recognizable unusual tissue patterns when the cervix is examined with the unaided eye. (3) Patients with tissues nonstaining to iodine. (4) Women who have had multiple pregnancies with varying degrees of cervical trauma. (5) Possibly all women using IUDs or taking birth control pills—merely as observation of any tissue change from long-standing use of these contraceptive methods. (6) Women with prolonged cervical infections, especially trichomoniasis. (7) All patients who have had conization, hysterectomy or irradiation therapy for uterine malignancy, the colposcopic examination being combined with cytology as a follow-up study to detect any residual or recurring lesions on the vaginal mucosa. (8) Patients receiving cryotherapy for any cervical lesions should be followed by colposcopic examinations. (9) Young women with persistent irregular vaginal bleeding should be examined regardless of age to rule out the possibility of vaginal adenosis and/or adenocarcinoma. (This is particularly important if at the time of their own early embryonic development the patients' mothers had taken synthetic estrogens.) Colposcopy may be most helpful in the diagnosis and clinical management of these conditions.

Colposcopy has been used extensively in some countries since Hinselmann[4] published his first clinical experiences with the method in 1925. There is now rapidly expanding interest in colposcopy in the United States, as evidenced by the numerous articles appearing in the literature, the inclusion of the subject matter in scientific programs on gynecological oncology, and the establishment of teaching centers for the study and clinics for the care of patients by colposcopic techniques. Stafl and Mattingly[12] report promising results from the efforts of the statewide satellite centers operating in Wisconsin.

Colposcopy can be self-taught, but expert assistance is recommended to instruct the beginner in the mechanical technique of using the instrument. The interpretation of what is observed requires careful clinical observation of tissues seen on live patients. In addition, a disciplined study of published materials is needful. Teaching aids are available. There are several Atlases of Colposcopy which present excellent illustrations and detailed descriptions of the various patterns observed. The most recent books serve an additional function as comprehensive bibliographies of the literature on colposcopy. Basic courses in colposcopy are offered periodically and several gynecological departments in teaching institutions are adding colposcopy to their training programs.

BIBLIOGRAPHY

1. Bolton, K.A.: Practical colposcopy in early cervical and vaginal cancer. *Clin. Obstet. Gynecol.* 10:808-837, 1967.

2. Coppleson, M., Pixley, E., Reid, B.: *Colposcopy. A Scientific and Practical Approach to the Cervix in Health and Disease,* Charles C Thomas, Springfield, 1971.

3. Fluhmann, C.F.: The squamo-columnar transition zone of the cervix uteri. *Obstet. Gynecol.* 14:133-148, 1959.

4. Hinselmann, H.: Verbesserung der Inspectionsmoglichkeiten von Vulva, Vagina and Portio. *Munch. Med. Wochenschr.* 72:1733, 1925.

5. Jones, H.W., Katayama, K.P., Stafl, A., Davis, H.J.: Chromosomes of cervical atypia, carcinoma in situ, and epidermoid carcinoma of the cervix. *Obstet. Gynecol.* 30:790-805, 1967.

6. Kaufmann, C., Ober, K.G.: The morphological changes of the cervix uteri with age and their significance in the early diagnosis of carcinoma. *Cancer of the Cervix, Diagnosis of*

Early Forms, Ciba Foundation Study Group No. 3, J. and A. Churchill Ltd., London, 1959, p. 61.
7. Kolstad, P.: Diagnosis and Management of Pre-cancerous Lesions of the Cervix Uteri. *Int. J. Gynaec. Obstet.* 8:551-560, 1970.
8. Kolstad, P., Stafl, A.: *Atlas of Colposcopy.* University Park Press, Baltimore, 1972, p. 21.
9. Navratil, E.: Colposcopy. In L. Gray (Ed): Dysplasia, Carcinoma in Situ, and Micro Invasive Carcinoma of the Cervix Uteri. Charles C Thomas, Springfield, 1964, p. 273.
10. Nunez-Montiel, J.T., Rodriguez-Barboza, J., Molina, R.A., et al.: Colposcopic exploration of the endocervix. *Prog. Clin. Cancer.* 4:203-210, 1970.
11. Richart, R.M.: A Theory of Cervical Carcinogenesis. *Obstet. Gynec. Survey.* 24:874-879, 1969.
12. Stafl, A., Mattingly, R.F.: Colposcopic diagnosis of cervical neoplasia. *Obstet. Gynecol.* 41:168-176, 1973.
13. Townsend, D.E., Ostergard, D.R., Mishell, D.R., et al.: Abnormal Papanicolaou smears: Evaluation by colposcopy, biopsies, and endocervical curettage. *Am. J. Obstet. Gynecol.* 108:429-434, 1970.
14. Younge, P.A.: The conservative treatment of carcinoma in situ of the cervix. In *Proceedings of the Third National Cancer Conference.* J. B. Lippincott Co., Philadelphia, 1957. ◄

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Florentia and the Clarabellas — A Tribute To Nurses

JACOB K. BERMAN, M.D.
Indianapolis

WHILE writing the History of the Western Surgical Association, I came upon the unsung and unheralded role of the nurse. This prompted me to pursue the history of nursing as a profession. Prescient women who saw the need for nursing care and who gave sedulously of themselves. Equally important, they organized helpers to enlist in their cause. Their importunate message was to care for the sick, the suffering, the injured or infirm—tenderly and with circumspection. Three named deserve special mention although many more are equally worthy.

Florence Nightingale

Florentia, which means soft and sweet, accurately describes this dedicated, highly motivated and unselfish woman. Born in Florence, Italy, educated in England and in Paris at the Institute of St. Vincent DePaul, she became the superintendent of the Hospital for Invalid Gentle Women in London in 1853. When the Crimean War broke out in 1854, Florence Nightingale, stirred by reports of the primitive sanitation methods and grossly inadequate nursing facilities at the large British Barracks Hospital in Scutari, Turkey, dispatched a letter to the British Secretary of War volunteering her services in the Crimea. Through her tireless efforts, the mortality rate among the sick and wounded was cut from 42% to 2% within a period of four months.

At the close of the war in 1860, friends and sympathizers raised a fund of $250,000 with which they opened the Nightingale School of Nursing at St. Thomas Hospital in London. This really marked the beginning of professional education in nursing, because Florence Nightingale did not have any definite nursing instruction. In fact, nurses were looked upon as menial servants before Miss Nightingale's time. Her performance in the Crimean War was duplicated in the Indian (Sepoy) Mutiny, the American Civil War, and the Franco-German War of 1870-71. She was consulted frequently on questions concerning the organization and operation of camp hospitals.

She wrote many books, among them were the following: *Notes on Nursing* (1860), which was the first textbook for nurses. This was translated into many languages. *Life or Death In India, Notes on Nursing for the Laboring Classes,* and *Health Teaching in Towns and Villages.*

The poem written by Longfellow describes her efforts during the Crimean War more vividly than I can possibly depict. I quote a portion from this poem entitled, "Santa Filomena":

The wounded from the battle-plain
In dreary hospitals of pain,
  The cheerless corridors,
  The cold and stony floors.

Lo! in that house of misery
A lady with a lamp I see
  Pass through the glimmering gloom
  And flit from room to room.

And slow, as in a dream of bliss,
The speechless sufferer turns to kiss,
  Her shadow, as it falls
  Upon the darkening walls.

A Lady with a Lamp shall stand
In the great history of the land,
  A noble type of good,
  Heroic womanhood.

Clara Barton

Clara (from Clarabella which means, "to bloom") is a fitting name for Miss Barton.

If Clara had done nothing more for all of us, she would be known as the founder of the American Red Cross. Born in Oxford, Mass., she lived to be 91 years of age. During the Civil War she solicited supplies and she nursed the soldiers, many of whom were suffering from typhoid and from dysentery and allied diseases. During the Franco-Prussian War in 1879 at the Geneva International Conference of the Red Cross, she secured the passage of an amendment to the International Red Cross to care for the injured and sick in peacetime catastrophes and holocausts. She helped in the Johnstown, Pa., flood of 1889, the Russian famine of 1892, the Armenian Massacre in 1896, Cuba in the Spanish-American War in 1898, and the Galveston, Texas, flood in 1900.

She was the author of many texts, but I was impressed more by Clara Barton's role during the Civil War where she became the nursing superintendent. There was no organized army nurses' corps although training schools were in existence and trained nurses were available; furthermore, there was no system by which nurses could be provided for war service. Miss Barton recruited and trained women to help the sick. Actually, more soldiers died from typhoid, dysentery and other diseases than from bullets. Therefore, to Clara Barton we owe not only much for her past performance but also for her farsighted concepts of the role of nursing. We might ac-

curately state that thousands of lives have been saved through her ministrations. Her teachings live today because of the inspiration which she gave to her students, who, in turn, have stimulated new generations of nurses year after year.

Clara Maass

Miss Maass was another Clarabella whose life portrays a story of unselfish devotion to her fellowmen. A true tale of sacrifice for the good of humanity which remains unsurpassed in the annals of nursing.

Clara was one of eight children and became her mother's helper at an early age. She had to work very hard to help provide for meals and support for the large family. Her father was a hat maker whose earnings were extremely meager. She got a job in the Newark, N.J., Orphan Asylum at age 15 and sent most of her $10 monthly salary home to her mother.

In 1893, Clara heard, with amazement, that the Newark German Hospital (now known as the Clara Maass Memorial Hospital) was prepared to train young girls to become nurses and that they would not charge anything for this training. So she became a probationer at 16. Two years later, she wore her cap proudly as Nurse Clara Maass. This beautiful and unselfish young woman immediately began to offer her services to all who suffered or who were sick or infirm. She volunteered for service in the Spanish American War and stayed briefly at army camps in Jacksonville, Fla., and Savannah, Ga., before reaching Santiago, Cuba. In Cuba, she learned of the horror of yellow fever.

She was discharged from the army in 1899 and volunteered for service in the Philippines. This was in the fall of 1900 and she requested that "I be sent on the first transport leaving." Yellow fever was present in the Philippines, too, and also a disease known as break-bone fever, technically known as Dengue Fever. It is also known as Dandy Fever or Solar Fever. It is carried by a mosquito known as *Aedes aegypti* or *Aedes albopictus*. While nursing in the Philippines, she contracted this disease and was very sick, but she slowly recovered and was sent home. After a brief interval, she volunteered for yellow fever experiments in Cuba. Most Cubans philosophically accepted the sickness as only another complication of life. But a team of United States physicians and a Sanitary Commission in Havana had singled out the mosquito as the probable transmitting agent or vector. They needed proof. Among the members of this commission was Dr. Carlos Finlay, a graduate of Jefferson Medical College. Other members of this commission were Drs. James Carroll, Aristides Agramonte, Jesse W. Lazear and Walter Reed. The commission soon listened to Dr. Finlay, who had been striving for 19 years to convince his medical colleagues that yellow fever was transmitted by a common house mosquito.

Clara worked with the Havana Commission in the isolated village of Quemados, where an experiment had shown that yellow fever was not passed directly from person to person. So a room was carefully sealed off to kill all mosquitos and then occupied by three non-immune people who wore the pajamas and slept in the bedding of yellow fever victims. The three were not stricken. Therefore, fomites were not responsible for the epidemic of yellow fever. Since yellow fever was not caused by the fomites, it had to be carried by vectors. The only way to prove this scientifically was to have humans bitten by a mosquito which had previously fed on yellow fever sufferers. Clara Maass joined 20 volunteers and wrote her mother a disarming note:

> Do not worry, Mother, if you hear that I have yellow fever. Now is a good time to catch it if one has to. Most of the cases are mild, and then I should be immune.

She developed a "light case," after being bitten on June 4, 1901. She recovered and offered her arm for another bite on August 14. This time the fever tore through her tired body, proof positive of the power of the mosquito to bring mankind to the edge of engulfment. Death came

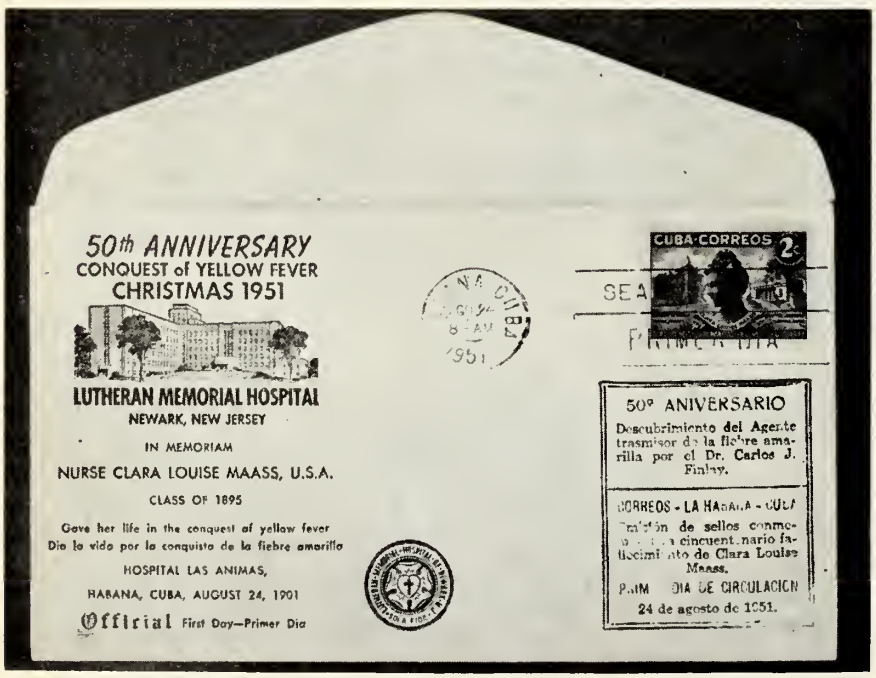


Photo of original stamp and envelope issued by the Cuban government in memory of Clara Maass, R.N., on the 50th anniversary of her death (courtesy of J. L. Pedicini, M.D., East Orange, N.J.)

to Clara on August 24 in Las Animas Hospital in Havana at age 25. Several Cuban volunteers also died, but Clara was the only American and the only woman to succumb. The mosquito responsible for carrying the virus was the *Aedes aegypti.**

Clara Louise Maass was brought home for burial in Fairmount Cemetery, Newark, N.J. Cuba issued a stamp in her honor in 1951 on the 50th anniversary of her death. (See illustration.) For quite a while, Clara's fearless, unselfish and heroic sacrifice remained unknown and her burial place was marked only by a headstone. However, her burial in the Fairmount Cemetery in 1902 was soon marked by a suitable monument. In 1912, a room was set apart in the Newark German Hospital. In 1952, the hospital was rebuilt in Bellville, N.J., and its name was changed to the Clara Maass Memorial Hospital. It has 300 beds with a training school for nurses.

*The mosquito vectors vary in different countries where the disease is endemic. For example, jungle yellow fever occurs in the jungle regions of South America and Africa and is transmitted in South America and Africa by the *Aedes leucocelaenus* and in Africa by *Aedes simpsoni.*

Contemporary Nurses

If there exist guardian angels who guard the sick and the wounded in their ofttimes hazardous flight back to health, then surely the nurse must be their earthly counterpart. The nurse goes into training with those intangible, sacred qualities known as kindness, empathy, and a genuine desire to help the ill, the injured, the suffering, or the infirm, just as did her forebears in her profession. We have seen that the early nurses had very little formal training in the actual techniques of nursing. Those of us who teach the nurses and who try to educate and train them simply provide the tools of knowledge which make them perform their duties more expertly; but the motivation and the selfless desire to serve is within them long before they go into training. Disregarding their own health, fatigue or financial reward, they serve willingly and efficiently. In good weather and bad, in summer and winter, day and night, they go silently without complaint to give succor to those who suffer. They seek to help the physician to allay disquietude and to give comfort and hope to the afflicted. Often overworked, they do not complain. Frequently blamed for unavoidable delays, they respond with the motto that "The patient is always right," even though this is often inaccurate.

As we review the history of nursing in the past, we find that the present average nurse, like her heroic predecessors, is just as highly motivated and dedicated. Truly, the nurse presents an effulgent spectacle of an inspired desire to help people—all people. ◄

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Please reserve _____ box lunches)

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Health Needs Survey: Greene County, Indiana

BARBARA L. ROBERTSON, Ed.D.
JOHN SVAAN, Ph.D.
Indianapolis

EARLY in 1973, members of the Greene County Health Program Group requested that the Indiana Regional Medical Program make a study of health needs in Greene County. Concern had been expressed that health needs were not being adequately met in the county, but there was little objective evidence to support this claim. It was, therefore, decided to undertake an investigation to provide information identifying the health needs of the citizens of the county and describing the facilities and services available to meet those needs.

A survey was conducted in April, 1973 to obtain information from both providers and consumers. The providers included doctors, nurses, and personnel of the hospital and the four licensed nursing homes. Two samples of consumers were obtained: the parents of all third graders in the local schools, and elderly citizens identified through the Housing Authority at Bloomfield and the County Extension Service throughout the area.

There was a 50.3% return on the consumer questionnaires, while the provider response ranged from 75% for physicians to 100% for hospital personnel. Responses were analyzed and tabulated with accompanying comments for the Greene County Health Program Group. The needs that are listed in the following paragraphs represent key points in the "Recommendations" section of the report.

1. The development of an adequate sewage system is primary. In this venture the city councils of the six main cities in the county could well develop a cooperative program. It would then be feasible to hire a consulting engineer to provide a preliminary report and cost estimate. The consultant could then approach the Indiana State Board of Health in order to seek federal assistance, possibly from the Federal Housing Authority, the Housing and Urban Development Agency, or the Environmental Protection Agency.

2. The shortage of physicians in Greene County is a major concern and requires immediate attention.

Only one of the fourteen physicians in the county has less than 20 years experience, which indicates a need to consider this a problem of some urgency. Attempts to attract physicians to work in this area have, up to now, been unsuccessful. Therefore, additional strategies should be explored. One suggestion is that medical services could be augmented by using Health Access Stations, such as the one in Rochelle, Georgia. The Health Access Stations are manned by nurses who are in telephonic communication with physicians in larger cities. Nurses with special training can deal with a great number of minor ailments efficiently and with reduced expense, and the time of the physicians could be devoted to patients with more serious ailments. It would be desirable for each of the six main cities to have such a station to augment the work already being done.

3. Greene County physicians may wish to contact medical specialists in Bloomington and Terre Haute about the possibility of working out an agreement to spend time in Greene County delivering their services on a one-day-a-week basis. This would be especially useful, initially, in the area of geriatrics.

4. A quality continuing education program for nurses is recommended as one of the services performed in the new hospital.

It is suggested that the hospital request assistance from the Bloomington Hospital in planning programs at the Greene County General Hospital for nurses in both areas. In addition, the Greene County General Hospital nurses could be invited to attend programs in Monroe County as well.

5. Nurses should be used more widely in schools and housing authorities in the area. Nurses are capable of dealing with a number of minor complaints and could provide such services as making house calls for elderly patients who have difficulty in making trips to physician's offices.

6. The shortage of dentists and the number of people who do not receive dental care present another problem.

It is suggested that alleviating the dental care problem can best be accomplished through prevention strategies oriented toward the children in the schools. Muncie and Columbus have recently appointed

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Dr. Robertson was program associate with Indiana Regional Medical Program at the time this study was conducted.

Dr. Svaan is director of research and evaluation for the Indiana Regional Medical Program.

A limited number of copies of the entire report, of which this is a condensed version of the Recommendations chapter, are available; requests should be addressed to Dr. Svaan, 1300 West Michigan St., Indianapolis 46202.

dental hygienists who work solely in the schools. Perhaps the Board of Education and the Board of Health could combine to pay the salary of a dental hygienist and thus help meet the need. Another alternative is to approach the Dental Division of the State Board of Health and request it to institute as many of its programs as possible. This division supplies free literature and movies for children. In addition, there is a self-application "Brush-in" program which costs 25 cents per child. The children receive toothpaste and a toothbrush for 25 cents. Reports indicate that in some communities these programs have cut decay to one-third.

Another alternative is the referral card program, in which cards are given to children to take home to provide the motivation for parents to take the children to a dentist for an examination. The Indiana State Board of Health offers in-service Teacher Training Programs in which a dental hygienist, a dentist, and a nutritionist work with teachers and help them provide meaningful dental health lessons for their students. It is recommended that as much use as possible be made of these programs.

7. The County Health Department should be assisted in obtaining greater financial aid in order to expand its program.

A great deal of work is already being done by members of this group. Further assistance should enable them to make an even greater impact on the health needs of the county in general. The use of a consulting engineer to assist in obtaining federal funds for the county is suggested.

It should be emphasized that this survey represents only a first step toward developing action programs. Not only must there be a gathering and analyzing of information, but the needs that arise from the data should be ranked in order of priority. Additional information will probably be needed as well. Only by employing a systematic approach will effective decision making and planning result. ◄



CANCER CORNER

New information from
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American Cancer Society, Inc.
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TELETAPE is a medical information service on cancer provided to physicians, dentists and nurses. Six to seven minute pre-recorded medical lecture-consultations are available. Call toll-free 1-800-382-1579 (in Indianapolis call 257-5329).

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Mail this coupon to the above address for a free booklet giving description of 200 tape-recorded messages concerning treatment of cancer problems.

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TO ALL PHYSICIANS IN INDIANA:

We are currently interested in obtaining any adult patients with acute leukemia. Although we would prefer previously untreated patients, we are interested in any phase of their disease.

At the present time, we are currently using a combination of Cytosine Arabinoside + intravenous 6-MP as an investigational Phase II combination and have initial excellent results. We are most interested in having any adult patient over the age of 15 referred to our Medical Center with acute leukemia.

Lawrence H. Einhorn, M.D.
IUMC, Emerson Hall Room 435
1100 West Michigan
Indianapolis 46202

Fun in the Fall at the Inn of the Four Winds, Monroe Reservoir

September 11, 12, and 13 are the dates for the Cancer Symposium for the Primary Care Physician. The purpose of this symposium is to present new advances in the diagnosis and treatment of cancer which are of practical importance to the primary care physician. Speakers include specialists in cancer diagnosis and treatment. Sessions will terminate at 1:15 p.m. each day, so that ample advantage may be taken of the extensive recreational facilities and exquisite American-International cuisine at the Inn.

For a listing of program speakers refer to the July issue of the ISMA Journal. Additional information can be obtained by writing Methodist Hospital Graduate Medical Center, Medical Education Department, 1604 North Capitol Ave., Indianapolis 46202.

Colon-Rectum Cancer

Cancer of the colon and rectum will strike 99,000 Americans this year, claiming more victims than any other type of cancer except skin. It occurs about equally in men and women. Some 48,000 die of it annually—though almost three out of four patients might be saved by early diagnosis and prompt treatment.

WARNING SIGNAL: Bleeding; change in bowel habits.

SAFEGUARDS: Annual checkup including proctoscopy, especially for those over 40.

COMMENT: Considered a highly curable disease when digital and proctoscopic examinations are included in routine checkups.

LITERATURE AVAILABLE

Mass Screening for Colorectal Cancer

This is a reprint of a paper presented by Dr. James B. Hastings. Dr. Hastings describes a successful screening program for the detection of colorectal cancer conducted in 15 centers in Mercer County, New Jersey. The project was based on a study suggesting that bleeding from early tumors can be effected by a high roughage, irritating diet. Dr. Hastings strongly urges the use of equential guaiac testing with dietary preparation both as a mass screening effort and as a routine office procedure.

Cancer Incidence, Survival and Mortality for Children Under 15 Years of Age

This material is offered to fill the great need for statistical information on childhood cancer. Data on cancer in children has been compiled on a comprehensive basis for a representative area of the country and is based on a large number of cases. These materials, compiled by the National Cancer Institute, give improved insight into the problem of childhood cancer.

(The above literature can be obtained by writing to the Indiana Division, ACS, 2702 E. 55th Place, Indianapolis 46220.)

SEMINARS FROM



RILEY CHILDREN'S HOSPITAL

Treatment of Pneumonias in Infants and Children

JOHN RYAN, M.D.
Indianapolis

As with all infections, the optimal treatment of pneumonia depends on isolation of the microorganism and determination of its antibiotic sensitivity. The physician should consider the possibility that a pneumonia may be caused by a virus or mycoplasma and treat accordingly. Otherwise, one must decide to treat as a bacterial pneumonia and consider the most likely etiologic agent.

In patients ill enough to be hospitalized, it is worthwhile obtaining blood for culture, since isolation of an organism provides the diagnosis. There is considerable doubt whether culturing the secretions of the nasopharynx is worthwhile. In a recent study, Eichenwald[1] compared the organisms found in various sites to the organism obtained from direct lung aspirate. The pharynx yielded the same organism as the lung aspirate 11% of the time, while the anterior nasal area had the same organism 13% of the time. Puncture of the trachea or tracheal aspirate yielded the same organism as the lung aspirate 20% of the time.

One should also consider a thoracentesis if pleural effusion is present, with cell count, glucose and protein determination and gram-stain with culture. Percutaneous lung aspiration is a more aggressive diagnostic measure that should be considered when: 1) a patient is critically ill and there is an urgent need to make a specific diagnosis; 2) a patient is not improving or may, in fact, be worsening while on therapy; 3) a patient is on immunosuppressive therapy or in some other way has a compromised defense system which makes him susceptible to unusual pathogens.

Usually one begins therapy by making an educated guess as to what the most likely organism(s) is (are). This differs considerably by the age of the patient.

Initial Therapy

Neonates

In the neonate, pneumonias are caused by gram-negative bacilli as well as gram-positive cocci, especially streptococci in the newly born.[2] *Staphylococcus* would be a consideration in the premature infant who may have been in the nursery for a while, or who has had a complicated course of hyaline membrane disease.

A penicillin is the best drug for gram-positive cocci. If the clinician suspects *Staphylococcus,* then a penicillinase-resistant penicillin is necessary. If this seems unlikely, penicillin G or ampicillin may be used. Ampicillin would also provide coverage for enterococci and some strains of *E. coli* and *Proteus* species. Kanamycin or gentamicin should be added to complete coverage for the gram-negative organisms. The choice between kanamycin and gentamicin will depend on the susceptibility of the gram-negative organisms in a local area.[3] This will differ in various communities. In the Indiana University Medical Center nurseries the enterobacter remain sensitive to kanamycin.

If *Pseudomonas* seems a likely possibility, gentamicin would be the antibiotic of choice since kanamycin is not active against this organism.

Blood cultures in neonates should be drawn from a peripheral vein, because blood drawn from an umbilical vessel is notorious for misleading information. Resist the temptation to draw blood cultures from catheters in umbilical vessels.

Infants and Pre-Schoolers: One Month-Four Years

Viruses are important as a cause of pneumonia in children, especially in the first year of life.[4] One cannot always decide for certain that viral infection is present, but the follow-

From the Department of Pediatrics, Indiana University Medical Center, James Whitcomb Riley Hospital for Children, Indianapolis 46202.

Supported by the James Whitcomb Riley Memorial Association.

ing suggest a viral illness: Biphasic illness consisting of upper respiratory infection, symptoms of cough, pharyngitis, fever, hoarseness followed by a febrile period during which there is exaggeration of the fever and cough.[5] Peripheral white blood count of greater than 20,000 is more likely to be associated with bacterial infection, while a WBC of 20,000 or less is compatible with viral pneumonia. Early in viral infections there may be a high proportion of polys and non-segmented polymorphonuclear leukocytes.

Pleural effusions are not unknown in viral pneumonias, but they are more likely to occur with bacterial pneumonias. Consolidation of an area seen by chest film is reason to suspect bacterial pneumonia, while patchy bilateral infiltrates are more likely to be viral pneumonia.

Some physicians will observe a child closely when the evidence points strongly to viral pneumonitis. There is, of course, no reason to suspect that antibiotics in this situation prevent bacterial infection. The ecology of the respiratory tract is diverse and antibiotics only select resistant strains of the endogenous flora. Others feel uncomfortable not treating pneumonias or feel that if they cannot be certain of the diagnosis of viral pneumonia, they should give antibiotics to cover the most likely etiologic agent.

The most likely organism causing bacterial pneumonia is *Streptococcus pneumoniae (Diplococcus pneumoniae)*[6] for which penicillin is the drug of choice. There is controversy regarding the role of *H. influenzae* as a cause of pneumonia in this age group, and some physicians are of the opinion it is a major concern, in which case ampicillin would be the antibiotic of choice because it provides coverage for both *H. influenzae* and *S. pneumoniae*. In a patient allergic to penicillin, erythromycin or chloramphenicol may be used. Over the past several years *Staphylococcus* has become a less frequent cause of pneumonia. However, it is well to remember that in large series of staphylococcal pneumonias,[7] it has been shown that the majority occur in the first year of life. A child with a rapid onset of pneumonia in whom one sees empyema, abscesses or pneumatoceles must be considered to have *Staphylococcus* until proven otherwise. Initial therapy in that situation should include a penicillinase-resistant penicillin: methicillin, oxacillin or nafcillin.

Children of School Age

In children of school age, the most common cause of bacterial pneumonia is still *Streptococcus pneumoniae* (pneumococcus), for which penicillin G is the drug of choice. *Mycoplasma pneumoniae* is also a frequent cause of pneumonia in the school age child.[8]

Specific Antimicrobial Therapy

Pneumococcal pneumonia

Penicillin G is the drug of choice. Erythromycin and clindamycin are

ANTIBIOTICS USED IN TREATING BACTERIAL PNEUMONIA
Neonates

Antibiotic	Dose Schedule	
Ampicillin	less than 6 days of age 100 mg/kg/day q 12 h.	1-4 weeks 200 mg/kg/day q 8 h.
Cephalothin	100 mg/kg/day q 12 h.	200 mg/kg/day q 8 h.
Chloramphenicol	Premature less than 6 days 25 mg/kg/day q 6 h.	
	Full Term less than 6 days 25 mg/kg/day q 6 h.	
	Premature 1-4 weeks 25 mg/kg/day q 6 h. 50 mg/kg/day q 6 h.	
Gentamicin	less than 6 days of age 5 mg/kg/day q 12 h.	1-4 weeks 7.5 mg/kg/day q 8 h.
Kanamycin	15 mg/kg/day q 12 h.	15 mg/kg/day q 12 h.
Methicillin	less than 6 days of age 100 mg/kg/day q 12 h.	1-4 weeks 200 mg/kg/day q 8 h.
Nafcillin	less than 6 days of age 100 mg/kg/day q 12 h.	1-4 weeks 200 mg/kg/day q 8 h.
Oxacillin	less than 6 days of age 100 mg/kg/day q 12 h.	1-4 weeks 200 mg/kg/day q 8 h.
Penicillin G	less than 6 days of age 50,000 units/kg/dose q 12 h.	1-4 weeks 200,000 units/kg/dose q 8 h.

ANTIBIOTICS USED IN TREATING BACTERIAL PNEUMONIA
Infants and Children

Antibiotic	Route	Dose Schedule
Ampicillin	P.O. IM or IV	100-200 mg/kg/day q 8-12 h. 200 mg/kg/day q 8-12 h.
Cephalexin	P.O.	100 mg/kg/day q 4-6 h.
Cephalothin	IM or IV	200 mg/kg/day q 4-6 h.
Chloramphenicol	P.O. IV *	50-100 mg/kg/day q 6 h. 50-100 mg/kg/day q 6 h.
Clindamycin	P.O.	10-20 mg/kg/day q 6-8 h.
Cloxacillin	P.O.	100 mg/kg/day q 6-8 h.
Dicloxacillin	P.O.	100 mg/kg/day q 4-6 h.
Erythromycin	P.O. IV	30-50 mg/kg/day q 6 h. 40-50 mg/kg/day q 6 h.
Gentamicin	IM or IV	5-7.5 mg/kg/day q 8 h.
Kanamycin	IM	15 mg/kg/day q 8-12 h.
Lincomycin	P.O. IM or IV	30-60 mg/kg/day q 6-8 h. 10-20 mg/kg/day q 8-12 h.
Methicillin	IM or IV	200 mg/kg/day q 4-6 h.
Nafcillin	IM or IV	200 mg/kg/day q 4-6 h.
Oxacillin	P.O.	200 mg/kg/day q 4-6 h.
Penicillin G	P.O. IM or IV	100,000 units/kg/day q 4-6 h. 100,000-200,000 units/kg/day q 4-6 h.
Penicillin V	P.O.	50-100 mg/kg/day q 4-6 h.
Phenethicillin	P.O.	50-100 mg/kg/day q 4-6 h.

* Not reliably absorbed from IM route.

considered suitable alternatives in a patient allergic to penicillin. However, there may be cross-resistance between lincomycin-resistant and erythromycin-resistant strains of pneumococci. One may treat mild to moderate infections with an oral preparation, Phenethecillin or phenoxymethyl penicillin being the preparation of choice. Severe infection or infections complicated with empyema or abscess require parenteral therapy. Aqueous penicillin IM gives good levels but, because it is painful, most prefer IV therapy.

A single dose of benzathine penicillin G may provide serum bactericidal activity for more than 14 days. However, failures have been reported with this treatment schedule and currently it is not recommended.[9] Duration of antibiotic therapy depends on the clinical response. In general, therapy should continue until the patient has been afebrile a minimum of three days and there is significant clearing of the chest film. The patient should not be released from medical care until there is complete clearing of the chest film.

Staphylococcal pneumonia

Since about 50% of staphylococci are resistant to penicillin G, a penicillinase-resistant penicillin should be the initial therapy whenever staphylococcal pneumonia is strongly suspected. If the isolate is later found to be sensitive to penicillin G, then this is the drug of choice for continued treatment. Staphylococcal pneumonia may have a rapid clinical course with formation of empyema, pneumatoceles and abscesses; this demands the best medical and nursing care a community can muster. In severe staphylococcal pneumonias, one usually gives parenteral therapy a minimum of three weeks and may then switch to oral therapy for another three weeks. *Staphylococcus* produces very necrotizing infection demanding high levels of antibiotic for long periods of time. A total of six weeks of antibiotic therapy is considered desirable to minimize the chance of relapse. Oral penicillinase-resistant preparations of choice are cloxacillin or dicloxacillin.

Hemophilus influenzae pneumonia

The frequency of *H. influenzae* as

a cause of acute pneumonia in hospitalized children has been variously estimated as 1 in 2,316,[10] 1 in 900[11] and the most recent estimate has been 1 in 833.[12] Honig et al.[12] have summarized the clinical features as follows: Usually lobar, but either bronchopneumonia or disseminated pulmonary disease has been seen; pleural effusions and empyema have been found; onset is usually insidious, but may be acute. Four of their five patients were over the age of five years.

Pneumonias due to other gram-negative bacteria

The rationale for choice of antibiotics has been given in the discussion of neonatal pneumonias. Once again, the duration of therapy depends on the rapidity of the clinical response and involvement, as demonstrated by chest films.

Mild to moderate disease should be treated a minimum of three afebrile days while severe disease may be treated 4-6 weeks as outlined with staphylococcal pneumonia.

Supportive

1). Use antipyretics as little as possible, since the fever curve provides a good index of therapy. Remember, not all patients respond the same and some may remain febrile for several days even though the antibiotic therapy is correct.
2). Administer humidified oxygen as needed for cyanosis and restlessness.
3). Maintain fluid and electrolyte balance. Remember, fever increases insensible loss and there is decreased insensible loss if cool mist is given.
4). Bronchoscopy should be considered if an atelectatic segment is not clearing.
5). Pleural effusions should be tapped initially for diagnostic material as well as therapeutic benefit. If they cannot be removed by repeated thoracentesis, then a chest tube connected through an underwater seal to a negative pressure pump is indicated. More than one tube may have to be inserted to appropriately drain the effusion or empyema and occasionally a rib resection with insertion of a larger tube may be necessary when fluid becomes loculated and cannot be removed otherwise. Chest tubes should be removed as soon as drainage is complete, since they may cause sinus tract formation or local tissue necrosis or may result in secondary infections. The instillation of antibiotics into the interpleural space is controversial. Some physicians do this, if fluid is loculated and there are adhesions. Antibiotics may be introduced into the pleural space after pleural fluid is aspirated. Some suggest irrigating the chest tube and then instilling aqueous penicillin G 10,000-50,000 units, ampicillin 10-50 mg or cephalothin 10-50 mg in 10 ml normal saline. Clamp tube one hour and release. Repeat 3-4 times per day while tube is in place.

It is generally believed that streptokinase has no role in treating empyema because it produces fever and local irritation.

REFERENCES

1. Eichenwald, H.F.: Respiratory tract infections in children. *Can. Med. Assoc. J.* 109:622, 757, 1973.
2. Finland, M., Fetal and perinatal pneumonia. Chapter 6 in Charles and Finland, *Obstetric and Perinatal Infections.*
3. Nelson, J.D., McCracken, G.H.: The current status of gentamicin for the neonate. *Am. J. Dis. Child.* 124:13, 1972.
4. Hilleman, M.R., Hamprian, V.V., Ketler, A., et al.: Acute respiratory illness among children and adults. Field study of contemporary importance of several viruses and appraisal of the literature. *JAMA* 180:445, 1962.
5. Cramblett, H.G.: Viral Pneumonia. Chapter 16 in *Pulmonary Disorders, Vol. I, Disorders of the Respiratory Tract in Children,* Kendig, E.L. Jr. (ed.) W.B. Saunders, Philadelphia, 1972.
6. McCracken, G.H., Jr., Eichenwald, H.F.: Pneumonia in *Textbook of Pediatrics,* 9th edition, Nelson, W.E., Vaughn, V.C.
7. Rebhan, A.W., Edwards, H.E.: Staphylococcal Pneumonia—Review of 329 cases. *Can. Med. Assoc. J.* 82:513, 1960.
8. Glezen, W.P., Denny, F.W.: Epidemiology of acute lower respiratory disease in children. *N. Engl. J. Med.* 288:498, 1973.
9. Klein, J.D.: Bacterial Pneumonia in *Current Pediatric Therapy,* Gellis, S. and Kagan, B.M. W. B. Saunders Co., Philadelphia.
10. Ravitch, M.M., Fern, R.: The changing picture of pneumonia and empyema in infants and children. *JAMA* 175:1039, 1961.
11. Cronell, J., Loube, S.D.: Primary *Hemophilus influenzae* pneumonia. *Arch. Intern. Med.* 93:921, 1954.
12. Honig, P.J., Pasquariella, P.S. Jr., Stool, Sylvan, E.: *Hemophilus influenzae* pneumonia in infants and children. *J. Pediatr.* 83:215, 1973. ◄

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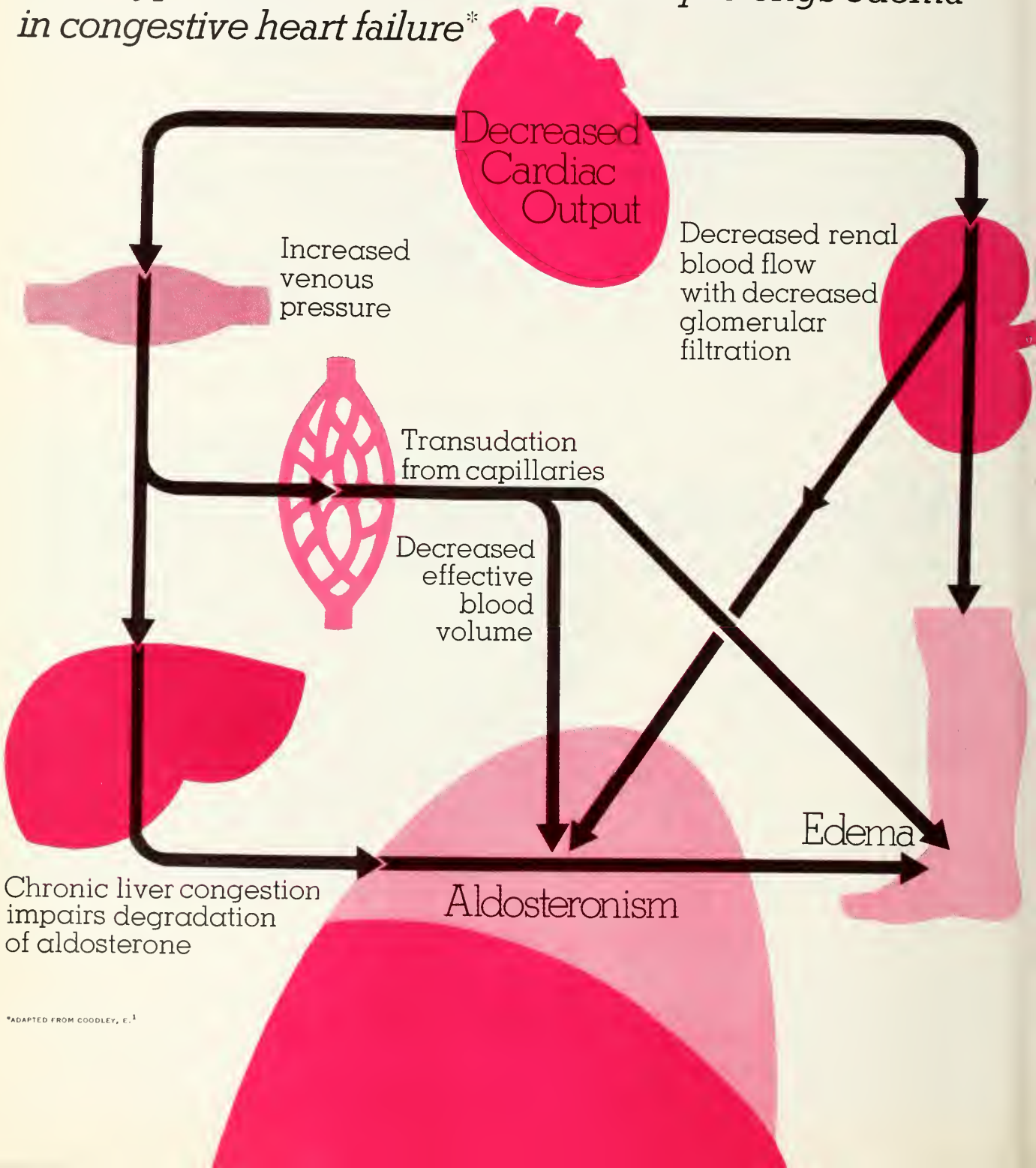
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Contraindications—Acute renal insufficiency, rapidly progressing impairment of renal function, anuria and hyperkalemia.

Warnings—Potassium supplementation may cause hyperkalemia and is not indicated unless a glucocorticoid is also given. Discontinue potassium supplementation if hyperkalemia develops. **Usage of any drug in women of childbearing age requires that the potential benefits of the drug be weighed against its possible hazards to the mother and fetus.**

Precautions—Patients should be checked carefully since electrolyte imbalance may occur. Although usually insignificant, hyperkalemia may be serious when renal impairment exists; deaths have occurred. Hyponatremia, manifested by dryness of the mouth, thirst, lethargy and drowsiness, together with a low serum sodium may be caused or aggravated, especially when Aldactone is combined with other diuretics. Elevation of BUN may occur, especially when pretreatment hyperazotemia exists. Mild acidosis may occur. Reduce the dosage of other antihypertensive drugs, particularly the ganglionic blocking agents, by at least 50 percent when adding Aldactone since it may potentiate their action.

Adverse Reactions—Drowsiness, lethargy, headache, diarrhea and other gastrointestinal symptoms, maculopapular or erythematous cutaneous eruptions, urticaria, mental confusion, drug fever, ataxia, gynecomastia, inability to achieve or maintain erection, mild androgenic effects, including hirsutism, irregular menses and deepening voice. Adverse reactions are infrequent and usually reversible.

Dosage and Administration—For **essential hypertension** in **adults** the daily dosage is 50 to 100 mg. in divided doses. Aldactone may be combined with a thiazide diuretic if necessary. Continue treatment for two weeks or longer since an adequate response may not occur sooner. Adjust subsequent dosage according to response of patient.

For edema, ascites or **effusions** in **adults** initial daily dosage is 100 mg. in divided doses. Continue medication for at least five days to determine diuretic response; add a thiazide or organic mercurial if adequate diuretic response has not occurred. Aldactone dosage should not be changed when other therapy is added. A daily dosage of Aldactone considerably greater than 75 mg. may be given if necessary.

A glucocorticoid, such as 15 to 20 mg. of prednisone daily, may be desirable for patients with extremely resistant edema which does not respond adequately to Aldactone and a conventional diuretic. Observe the usual precautions applicable to glucocorticoid therapy; supplemental potassium will usually be necessary. Such patients frequently have an associated hyponatremia—restriction of fluid intake to 1 liter per day or administration of mannitol or urea may be necessary (these measures are contraindicated in patients with uremia or severely impaired renal function). Mannitol is contraindicated in patients with congestive heart failure, and urea is contraindicated with a history or signs of hepatic coma unless the patient is receiving antibiotics orally to "sterilize" the gastrointestinal tract.

Glucocorticoids should probably be given first to patients with nephrosis since Aldactone, although useful for diuresis, will not directly affect the basic pathologic process.

For **children** the daily dosage should provide 1.5 mg. of Aldactone per pound of body weight.

References: 1. Goodley, E.: Consultant 12:106-107, 109, 111, 113, 115 (July) 1972. **2.** Thorn, G. W., and Lauler, D. P.: Am. J. Med. 53:673-684 (Nov.) 1972.

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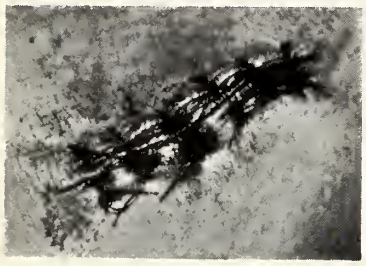
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Proposed Research Regulations Opposed

The American Academy of Pediatrics has expressed profound concern and dismay at regulations proposed by HEW dealing with protection of human subjects of medical research.

The Academy's Council on Pediatric Practice fears that the cumbersome, multi-layered system of review contemplated by the proposed regulations would halt practitioner research because of the sheer time involved in compliance.

The Council said that research into the efficacy of practice methods and systems of health care delivery would be seriously hampered by the proposed regulations.

The regulations which are objected to would require nearly all federally funded research to (1) Obtain the consent of both parents and of children who are seven years of age or older; (2) Provide for a Protection Committee to review the validity of the individual's consent; (3) Be reviewed and approved by an Organizational Review Committee; and (4) Be reviewed by three HEW groups—a Primary Review Committee, an Ethical Review Board and an appropriate secondary review group.

The regulations would also place other restrictions on research involving human subjects.

Guest Editorials

This editorial was written by Henry A. Davidson, M.D., distinguished editor of *The Journal of the Medical Society of New Jersey* for many years. It was published posthumously in the May 1974 issue of *The Journal, MSNJ,* Vol. 71, No. 5, and is reproduced here by special permission.

Among his many accomplishments in medicine during his lifetime, Dr. Davidson was noted for his editorials. This is one of his finest.—*Ed.*

English: The Number One Language of Medicine

TODAY, more articles in the biological sciences are written in English than in any other language. It was not always so, but these days, English is number one and others don't even come close. Some 24% of the world's biologic science papers are in English. The number two language, Russian, accounted for only 11%. Spanish came third with 8%. German was the language of original publication of only 7½% of the papers. Why should this be? How can any language with our absurdities of spelling and pronunciation have become the world's number one vehicle of communication?

In 1750, French was spoken by more people than any other language in the world. German, Spanish, Russian, and Italian came in that order, so that English was then outranked by five other languages.[2] But in 1973, more than 350 million people were using English as their primary tongue, and another 650 million were able to communicate adequately in English. Our language is understandable to almost a billion people: surely the greatest success story in communication since Latin was abandoned as Europe's lingua franca.[3]

The diffusion of English is due to the fact that it is a flexible language rather than an inflected one, that its grammatical structure is simple, and that one can learn it without being worried about masculine or feminine words, or trying to get adjectives to agree with the noun in gender, or remembering when to use the dative case. Indeed, principal credit goes not to the travelers' checks, but to the amazing flexibility of our language. We use nouns as verbs (you can really *chair* a meeting, or *fiddle* while the town burns), and verbs as nouns (ever hear of a *teach-in?*), adjectives as nouns (the *good* die young, remember?), and nouns as adjectives (ever go to a *bachelor* party?). A little word like *off* can be an adverb (my stock is always falling *off*) or an adjective (when that happens, it's an *off* day), or a preposition (play *off* key), or even

a verb (*off* with his head!). And the beauty of it is, you don't care, and probably don't know, whether you are using it as an adjective or a preposition. In English you use individual words like building blocks without worry about case, gender, or tense. ("Long time, no see" may be rejected by the purist as ungrammatical, but it does convey the idea.)

More than 70% of the world's mail is written in English.[4] That simple statistic states the case eloquently. There are more radio programs in English than in all other languages put together!

English has an exceptionally rich vocabulary. There is a world of difference, subtle or crude, between "to like" and "to love" but you can't use different words in French, German, Spanish, or Italian. Both concepts are expressed by *aimer, lieben, amar,* and *amare.* Then, too, English is more hospitable to and more readily naturalizes (Anglicizes or Americanizes) foreign words than any other language. Time was when you had to write in italics such alien imports as morale, habeas corpus, kibitz, and canyon. But not for long. They have slipped quietly into the mainstream of English and seem to have found a home with us. Thus, to say a courteous goodbye, the Semitic languages use "peace," which in their tongues is *sholem* or *salaam;* and English takes it up and transmutes *sholem* or *salaam* into "so-long"; and in this breezy form it goes wherever American soldiers go (practically everywhere). "So-long" is first Americanized and then exported to the wide, wide world.

Ogden[5] has shown that with a lean lexicon of fewer than 900 words, you can communicate adequately any idea you wanted, outside of advanced technologic or philosophic ones.[6] This would not be possible in a highly inflected or conjugated language, like Spanish or German.

Most of you who read these words will, like us, be native Americans for whom English is the mother tongue. But many of our readers were educated abroad; and that you can so fluently follow us is, in the first place, evidence of your own perseverance and intelligence. But it is also a tribute to the sophisticated, polished, and highly elastic language of ours—and yours. Barnett[7] quotes a Hindu by the name of Prem Bhatia, who was the editor of *The Times* of Delhi, India. This newspaper is printed in English. And Mr. Bhatia wrote: "We in India got rid of the British through the effective use of the English language. We quoted Macaulay and Edmund Burke and even Shakespeare." Oh well, practically everybody quotes Shakespeare.

BIBLIOGRAPHY

1. Survey made by *Biological Abstracts* of Philadelphia.
2. In all these calculations, Chinese is omitted. The major Chinese dialects are reciprocally incomprehensible to all but an educated upper crust. For most people in China, the understandable dialect is meaningful to perhaps 100 or 150 million. So little indigenous Chinese literature has been exported, that for all practical purposes, the language is immured in its country of origin and makes small impact on the science and literature of the rest of the world.
3. It is difficult to get accurate figures as to how many people speak a certain language. We have checked Frederick Bodmer's "Loom of Language" (New York, 1944, Norton), C. F. Hockett's "Linguistics" (New York, 1958, Macmillan), J. P. Hughes' "Science of Language" (New York, 1971, Random House), Mario Pei's "Story of Language" (Philadelphia, 1949, Lippincott), Simeon Potter's "Language in the Modern World" (Baltimore, 1960, Penguin), and Lincoln Barnett's "Treasure of Our Tongue" (New York, 1964, Knopf), and have found no two sets of figures that agree. Median figures for the seven languages that carry the great bulk of the world's scientific literature would seem to shape up as follows—in millions of people for whom this is the primary tongue: (For reasons indicated in footnote 2, Chinese is omitted) English: 350; Spanish: 140; Russian: 130; German: 100; Japanese: 95; French: 65; Italian: 55.
4. Barnett, Lincoln: *The Treasure of Our Tongue.* New York, Knopf, 1964, p. 7.
5. Ogden, C. K.: *Basic English.* New York, Harcourt-Brace, 1934.
6. We tried this out just for fun, and by using the verb "get" plus some other basic words, we found we could say "get better" (instead of improve), "get the better of" (instead of vanquish), "get him to go" (instead of eject him), "get up" (for arise), and such combinations as "get going" or "get your goat" or "get about" or even "I got him in the mouth," and so on and on. This is a minor illustration of the wonderful plasticity of our language.
7. Barnett, Lincoln: *The Treasure of Our Tongue.* New York, Knopf, 1964, p. 38. H.A.D.

HEW Is at It Again

WHENEVER a new directive comes from the Department of Health, Education and Welfare one gets the impression that nothing else can possibly surpass it in ineptitude, but promptly another one arrives that tops the last.

On December 19, 1973, Secretary Weinberger, in testifying before the Health Subcommittee of the Senate State Committee on Labor and Public Welfare, proposed to limit reimbursement for prescription drugs under Medicare and Medicaid "to the lowest cost at which the drug is generally available unless there is a demonstrated difference in therapeutic effect." For a moment the final clause "unless there is a demonstrated difference in the therapeutic effect" gave a fleeting glimmer of hope but Secretary Weinberger snuffed it out a moment later by saying that the Food and Drug Administration could assume responsibility for the uniform quality, efficacy and equivalency of all marketed drugs. This would be another example of calling on a boy to do a man's work.

The Pharmaceutical Manufacturers Association has pointed out, in view of the large number of drugs and manufacturers, and the FDA's limited capabilities, the agency cannot make these guarantees. The Department of Defense has discovered the unequal performances of differ-

ent drugs by various producers. For the period 1962 through 1971, the Military Defense Supply Agency, by far the largest single purchaser of pharmaceuticals, rejected 42% of drug product samples and 45% of production facilities inspected were given failing marks. The same manufacturers continue to operate and produce the same drugs rejected by the Department of Defense, ostensibly at least, with the approval of FDA. Could FDA possibly cope with the added burden Secretary Weinberger would place upon it?

We in Virginia had a recent example of FDA having to reverse itself following an ill-advised decision to withdraw sulfathaladine from the market. Many man-hours of effort were required by Dr. Charles E. Davis, of Norfolk, to remedy this situation. Physicians should not be diverted from their primary function—the care of the sick—to having to correct blunders made by FDA.

We are in accord with the Pharmaceutical Association in stating that "Physicians, pharmacists, and the general public would agree that the government should not interfere with professional judgment in choosing a particular drug product and identifying a preferred source. In the last analysis, only the prescribing physician is in a position to know which drug products have performed satisfactorily for his patients." The question also arises as to who would pay the additional cost if a physician should insist on prescribing a more expensive drug? If the patient were held responsible, this charge would not be consistent with the principles of the Medicare and Medicaid programs.

Perhaps HEW would permit a physician to prescribe a higher priced drug if he gave the particulars that prompted him to do so. A few time-consuming encounters on this order would doubtless discourage the most dedicated physician from exercising his own professional judgment and HEW ultimately would win out. It is significant that Dr. Charles Edwards, Assistant Commissioner of HEW, who later testified on behalf of Secretary Weinberger before the Health Subcommittee on February 1, stated HEW, while adhering to the original proposal, would need additional time to implement some of the recommended measures.

More could be written about the latest excursion of HEW into the field of medicine, but suffice it to say, if Secretary Weinberger succeeds in the proposal it will prove to be one additional nail in the coffin of independent American medicine.—**Harry J. Warthen, M.D., editor, The Virginia Medical Monthly, March 1974.**

Changing of the Guard

THE medical pathway is strewn with numerous well-camouflaged rocks and roots to trip the unwary physician. Even then, he may find that someone has removed the signpost that assured him he was on the right track, and he may be forgiven if he wonders if the journey is worth it. A recent decision of the Washington State Supreme Court (reprinted elsewhere in this issue from *The Citation,* Vol. 29, No. 2) is a reminder to the physician, if indeed he needs any reminder, that his lot should make any policeman happy with his own.

Briefly, a girl of 23 was fitted with contact lenses by one of partner-ophthalmologists. Intermittently over the next nine years (more frequently in later years), she was seen for complaints attributed to the lenses. She was then tested for glaucoma and found to have loss of peripheral vision and severely constricted central vision. Her suit alleged that her visual impairment was due to the ophthalmologist's negligence in failing to test her eye pressure and fields earlier. The defense was based upon the accepted ophthalmological standard that, in the absence of symptoms, routine testing of persons under 40 was not warranted because of the infrequency of the condition in this age group. The judgment of the trial court in favor of the defendants was reversed by the Washington Supreme Court on the grounds that the standards of the profession were not good enough and "it is the duty of the courts to say what is required. . . ."

The principle that a standard of practice acceptable to the profession and at least equivalent to that generally available in the community is the proper, safe, and judicially qualified criterion of professional conduct has long been a prime source of guidance, protection, and comfort to the physician. A reading of this extract of the judgment must certainly give him pause. It should be noted that both sides agreed that accepted professional standards exempted a physician from the obligation to test patients under 40 for glaucoma. The court held, however, that in this case it amounted to negligence that the test was not given, and its language leaves little doubt that an ophthalmologist will omit this "simple, harmless pressure test" in *any* patient at his own risk.

In essence, then, a high court has established the precedent that a standard of practice acceptable to the profession and equivalent to (or higher than) that in the community does not protect the physician from a finding of negligence. True, part of the court felt that "liability" was a more suitable description than "negligence," but this will be cold comfort to the physician. With conscious effort to avoid overreaction, we feel justified in viewing this as the displacement of medical standards of proper care in favor of standards imposed by another segment of society—in this case, the judiciary.

We do not contend that this case represents a gross miscarriage of justice. We think (hope, at least) that the ophthalmologists felt some sense of chagrin that this condition had been progressing while under their care. While standards of adequate care may have technically relieved them from responsibility, standards of *good* care, which we are sure they intended to give, could well be expected to have called for this testing somewhere along the line. A patient has suffered damage not through an

overt action of the physician but through the failure of a physician to apply his professional acumen to the optimum degree. The point is made that the patient presented no symptoms of glaucoma. We can even imagine that the discomforts which brought the patient in for consultation eight times in 17 months may have established her as a "complainer," which unhappy appellation is often a factor in diverting the physician from pertinent examinations and tests. Perhaps the significant word here is "routine." Although the patient under 40 is at slight risk for glaucoma and not in need of "routine" testing, was this case routine?

But, while the particular specifics of an individual case can generate endless argument, a precedent has been established—and precedent is a happy word to the legal profession. The fact that this judgment has been applied to an ophthalmological case and specifically in the state of Washington is no barrier to its application in other areas of medicine and geography. The individual physician feels the pressure of another lever on his professional function from an outside source. Unhappily, this may intensify the rancor that has often characterized the medical-legal relationship and which both sides have been working to alleviate.

Apart from the legal aspect of this case is the unfortunate effect it will have in the area of medical care costs. The physician has long recognized that many diagnostic or therapeutic procedures he may use are of minimal value, but he works under the ever-present threat that he may one day have to demonstrate that every possible potentiality of the case was explored. The concept of "defensive" medicine has produced no small amount of concern within the profession. There is a broad spectrum of attitudes. At one end is the physician who denies practicing defensive medicine on the principle that if he must perform tests or therapies of doubtful value because of extra-medical pressure, they constitute a necessary exclusive function and are, therefore, legitimate. At the other end is the physician who frankly accepts the defensive label, blaming its necessity on social forces not of his begetting. Thus they both wind up in the same place and, with their uncertain and inconsistent colleagues in between, combine to account for a significant utilization of medical resources (at appropriate expense), which is no better than tangential in its contribution to the patient's welfare.

It would be hard to find a situation that better epitomizes the conflict between the medical profession's concept of quality performance and the social concept of utilization. There is obvious irony in the fact that the court finds the physicians in this case guilty of *under*-utilization. We would like to think that the physician's application of his professional intelligence and motivation can be accepted as the prime determinants of adequate care. To have one of his principal supports displaced is not only professionally disquieting, it threatens him with being the unwilling contributor to a socioeconomic trend he heartily disapproves.

At the moment, the denial of this measurement of medical proficiency is more than just the arbitrary establishment of a new standard for, in fact, the court action offers no new, definitive standard for the physician. The court says it is its duty to act, and in this case it did. But its action leaves other physicians at other times required to perform their professional function with no assurance, short of other judicial action, that their efforts, however conscientiously applied, are "standard."

Ouch.—**David E. Gray, M.D., editor,** *Journal of the Kansas Medical Society,* **June 1974.**

The Arrogance of Physicians

IT is not surprising, considering our background and training and the need to convince ourselves and the public of our knowledge and competence, that many of us, at times, fall victim to baseless pride. We deal frequently with serious matters of life and death. And since most of us conscientiously try to give patients sound advice and provide proper diagnostic and therapeutic measures, we must first convince ourselves of the validity of our scientific information and the precision of our technical ability. In all of this we are better physicians if we do not remind ourselves too frequently of the inexactness of medical science.

There is little question that we are all, or most of us, guilty at times of consciously or unconsciously conveying the impression to a patient that he has received improper or inadequate treatment at the hands of another physician. It is sometimes difficult to do otherwise. To look at a patient with an obviously unsatisfactory therapeutic result and not have at least the fleeting thought that one could have done better himself requires more restraint, objectivity and humility than the average physician might be expected to develop in a lifetime of medical practice, even were he able to instantly recall half of his own poor results.

And yet it is incumbent upon us all to guard against the arrogance which is implied by even the transient thought that we could have done better under conditions and circumstances of which, at best, we can have only uncertain knowledge. The mere existence of the thought makes it difficult not to transfer to even the dullest patient the question in our minds. Admittedly this is not as inexcusable as the articulation of the criticism to the patient or to his relatives. Nevertheless, it may be equally damaging to the patient and to his physician.

Only rarely can criticism of previous treatment or diagnostic measures be expected to benefit the patient. It is possible that it might be necessary in an unusual situation in order to provide a patient with proper medical care. Mainly, though, overt criticism of a previous

physician's management of a case may be expected to compound the patient's discouragement and distress and serve no useful purpose so far as his further care is concerned. And the legal implications are obvious.

There is no wish here to condone or obscure physician incompetence or malpractice. The medical profession should just as assiduously ensure high standards of intellectual and technical competence as it should protect patients and physicians from criticism based on emotional reaction and inadequate information. It is, of course, important that the medical profession rid itself of the rare physician who represents a danger to the public. There are appropriate methods for accomplishing this. We must, however, take care to not, merely on the evidence of a bad result, condemn even inadvertently another physician. This can benefit neither the patient, the physician, nor the medical profession. **—H. C. Habein, Jr., M.D., Billings, Montana. From the** *Rocky Mountain Medical Journal,* **May, 1974. Reprinted with permission of the author and the** *Rocky Mountain Medical Journal.*

Looking Back

The wisdom of our elders. In March 1939 *The Journal* published in full an article reprinted from the *Ohio State Medical Journal* entitled "Do You Want Your Own Doctor . . . Or the "State Doctor"? The following are quotations which seem to be warning us about PSRO:

> What kind of medical care would you get? . . . You'd get a hasty diagnosis and the standard treatment. Remember the "state doctor" would have to spend a lot of time filling out forms and complying with red tape. Everyone knows that the sick are not in any sense standardized and that, therefore, mass treatment can never be successful. However, this fact will not make much impression on "the bureau" which will be particularly interested in figures and forms.
>
> —A.W.C.

Editorial Notes . . .

Drug prices have declined while almost everything else has gone up. PMA has figured that a non-farm worker with three dependents would have worked 32.4 minutes in 1973 to earn the cost of the same quantity of prescription drugs as would have required an hour's working time in 1960.

Migraine has been found to be unrelated to intelligence. It is found among patients at every level of intelligence, in every ethnic group and all types of genetic and environmental backgrounds. The American Association for the Study of Headache was told recently that old beliefs to the contrary have interfered with clinical research.

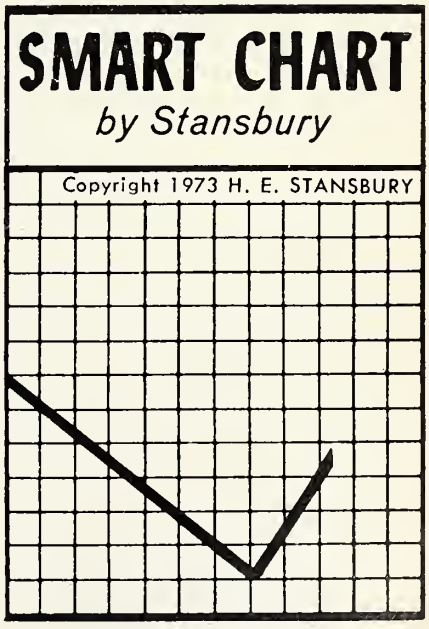
The Stanford Research Institute publication .INVESTMENTS IN TOMORROW predicts the continued and increasing use of dialysis, and the eventual refinement of the artificial kidney to a size which will fit in an attache case. The investment advice comes in with a prediction that kidney equipment, which runs about $8 million now, will be up to $240 million in 1980. While making predictions the article also predicts a totally implantable artificial heart which will run reliably for up to 2½ years—ready about 1980.

Fifteen years ago it was thought that women in general resented the birth control pill and its responsibilities. Whether they did then or not, a recent survey by Lederle shows that now they don't. Most of those interviewed said that, if there was a similar pill for men, they would not trust men to take it regularly. Reminds one of the old saw—if men got pregnant the birth rate would be less.

Fire authorities in Baltimore are worried about a recent Medicaid ruling to the effect that oxygen for home use is now reimbursable. Physicians are urged, when prescribing bottled oxygen for the home, to emphasize the safety rules in regard to smoking and the use of open flames such as gas stoves.

Cromolyn sodium, recently released by the FDA for treatment of chronic, intractable asthma, is reported by the National Asthma Center in Denver to be effective in the treatment of children. It has prevented attacks in some patients. Physicians have been able to reduce the dosage of corticosteroid drugs and steroid therapy.

Adverse drug reactions get a lot of publicity nowadays. The number of reactions and their seriousness increases every time some "expert" repeats the story. Drugs for the treatment of malignancy and autoimmune diseases are, by definition, of little value unless an adverse side effect is produced. The "experts" never acknowledge this fact. Another fact they never mention is that many of the adverse drug reactions (38%) are due to three old drugs—digoxin, quinidine and insulin.



"It's amazing what good accounting can do."

CME Accreditation Program Expanding

THE continuing medical education accreditation program of the Indiana State Medical Association launched in October 1973 continues to draw attention from institutions and organizations desiring recognition under the program.

Established as a part of the accreditation program of the American Medical Association, physicians attending courses in institutions, organizations or groups such as medical societies which have been surveyed and approved by the ISMA's site survey teams, may apply their hours of attendance to credit toward the AMA's Physician's Recognition Award for achievement in continuing education.

Thirty-six hospitals in Indiana have indicated interest in receiving CME accreditation from the Commission on Medical Education and Licensure, which developed the program and is responsible for its continuing progress.

To date, institutions which have been accredited are St. Joseph's Hospital and Memorial Hospital, both of South Bend; St. Joseph Memorial Hospital, Kokomo; Deaconess Hospital, Evansville, Reid Memorial Hospital, Richmond, and LaPorte Hospital, LaPorte.

Coordinating activities of the Accreditation Committee and the Site Visit Teams is Dr. Eugene M. Gillum, Portland. Chairman of the Commission on Medical Education and Licensure is Dr. Steven C. Beering, Dean, Indiana University School of Medicine. Instrumental in bringing the program to full development was Dr. Franklin A. Bryan of Fort Wayne, who served as chairman of the Commission during the years of planning.

One of the features of the program which will be of interest to physicians is that the scientific sessions of the annual ISMA Convention will be accredited for hours of recognition, giving added incentive for attendance.

Evidence that physicians are recognizing the importance of earning the AMA Physician's Recognition Award in continuing postgraduate education comes from Dr. Barbara Backer, medical education director of the LaPorte Hospital, who received numerous inquiries from physicians in her area as to how soon the CME program at the LaPorte Hospital would be accredited.

Quoting from Dr. Gillum on the subject of continuing education, "The need exists for personal growth, various kinds of recertification and even relicensure. Indiana has adopted a voluntary program of accreditation that, hopefully, will keep the quality of education high enough to meet all these needs."

Hospitals, medical societies and other organizations interested in the accreditation program should contact Dr. Gillum or Mr. Edward Raffensperger, ISMA staff.

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Instructions for Witnesses

YOU, as a witness in a lawsuit, have a very important job to do, since, in order for a jury to make a correct and wise decision, it must have all of the evidence put before it truthfully.

You already know that you take an oath in court to tell nothing but the truth. But there are two ways to tell the truth: one is in a halting, stumbling, hesitant manner, which makes the jury doubt that you are telling all the facts in a truthful way; the other is confident and straightforward, which makes the jury have more faith in what you are saying. You help yourself, the party you are testifying for, the judge and jury by giving your testimony in this last way.

To assist you, here is a list of time-proven hints and aids which, if followed, will make your testimony much more effective.

Suggestions to a Witness

1. As a witness to an accident, try to visit the scene before the trial. Stand on all corners and become familiar with the place. Close your eyes and try to picture the scene, the objects there, and the distances.

2. Before you testify, visit a court and listen to other witnesses. This will make you familiar with a court, and help you to understand what will happen when you give your testimony.

3. Wear clean clothes in court. Dress conservatively.

4. Do not chew gum while testifying or taking the oath.

5. Stand upright when taking the oath. Pay attention and say "I do" clearly.

6. Don't memorize what you are going to say.

7. Be serious at all times. Avoid laughing and talking about the case in the halls, restrooms, or any place in the courthouse.

8. Talk to the members of the jury. Look at them most of the time and speak to them frankly and openly as you would to any friend or neighbor. Do not cover your mouth with your hand. Speak clearly and loudly enough so that the farthest juror can hear you easily.

9. Listen carefully to the questions asked of you. No matter how nice the other attorney may seem on cross-examination, he may be trying to hurt you as a witness. Understand the question. Have it repeated if necessary; then give a thoughtful, considered answer. Do not offer a snap answer without thinking. You can't be rushed into answering, although, of course, it would look bad to take so much time on each question that the jury would think you were making up an answer.

10. Explain your answers, if necessary. This is better than a simple "Yes" or "No." Give an answer in your own words. If a question can't be truthfully answered with a "Yes" or "No," you have a right to explain the answer.

11. Answer directly and simply only the question asked, and then stop. Do not volunteer information not actually asked.

12. If your answer was wrong, correct it immediately.

13. If your answer was not clear, clarify it immediately.

14. The court and jury only want facts; not hearsay, or your conclusions or opinions. You usually can't testify about what someone else told you.

15. Don't say, "That's all of the conversation," or "Nothing else happened," Say instead "That's all I recall," or "That's all I remember happening." It may be that after more thought or another question you will remember something important.

16. Be polite always, even to the other attorney.

17. Don't be a smart aleck or a cocky witness! This will lose you the respect of the judge and jury.

18. You are sworn to tell the truth. Tell it. Every material truth should be readily admitted, even if not to the advantage of the party for whom you testify. Do not stop to figure out whether your answer will help or hurt your side. Just answer the questions to the best of your memory.

19. Don't try to think back to what was said in a statement you made. When a question is asked, visualize what you actually saw and answer from that. The jury thinks a witness is lying if his story seems too "pat" or memorized, or if he answers several questions in the same language.

20. Do not exaggerate.

21. Stop instantly when the judge interrupts you, or when the other attorney objects to what you say. Do not try to sneak your answer in.

22. Give positive, definite answers when at all possible. Avoid saying "I think," "I believe," "In my opinion." If you do not know, say so; don't make up an answer. You can be positive about the important things that you naturally would remember. If asked about little details that a person naturally would

not remember, it is best to just say that you don't remember. But don't let the cross-examiner get you in the trap of answering question after question with "I don't know."

23. Don't act nervous. Avoid mannerisms which will make the jury think you are scared, or not telling the truth or all you know.

24. Above all—this is most important—do not lose your temper. Testifying for a length of time is tiring. It causes fatigue. You will recognize fatigue by certain symptoms: (a) tiredness, (b) crossness, (c) nervousness, (d) anger, (e) careless answers, and (f) the willingness to say anything or answer any questions in order to leave the witness stand. When you feel these symptoms, recognize them and strive to overcome fatigue. Remember that some attorneys on cross-examination will try to wear you out until you will lose your temper and say things that are incorrect or that will hurt you or your testimony. Do not let this happen.

25. If you do not want to answer a question, do not ask the judge whether you must answer it. If it is an improper question, your attorney will take it up with the judge for you. Don't ask the judge for advice.

26. Don't look at your attorney or at the judge for help in answering a question. You are on your own. If the question is improper, your attorney will object. If the judge then says to answer it, do so.

27. Do not "hedge" or argue with the other attorney.

28. Do not nod your head for a "Yes" or "No" answer. Speak out clearly. The court reporter must hear.

29. If the question is about distances or time and your answer is only an estimate, be sure that you say it is only an estimate. Be sure to think about speeds, distances, and intervals of time before testifying, and discuss the matter with your attorney so that your memory is reasonable.

30. When you leave the witness stand after testifying, wear a confident expression, not a downcast one.

31. There are several questions that are known as "trick questions." If you answer them the way the other attorney hopes you will, he can make your answer sound bad to the jury. Here are two of them:

(a) "Have you talked to anybody about this case?" If you say "No," the jury knows that is not right because good lawyers always talk to a witness before they testify. If you say "Yes," the lawyer may try to infer that you were told what to say. The best thing to do is to say very frankly that you talked to whomever you have—lawyer, party to suit, police, etc.—and that you were just asked what the facts were. All you do is tell the truth.

(b) "Are you getting paid to testify in this case?" The lawyer asking this hopes your answer will be "Yes," thereby inferring that you are being paid to say what your side wants. Your answer should be something like: "No, I am not getting paid to testify. I am only getting compensation for my time off from work, and the expense (if any) it is costing me."

32. Except in a few situations, an insurance company cannot be joined as a defendant, and if anything is said that will let the jury know that an insurance company is actually defending the case, the judge will declare a mistrial. The jury will be discharged, and the case started all over. Therefore, be careful not to mention insurance.

33. Go back, now, and reread these suggestions so you will have them firmly in your mind. We hope they won't confuse you. We hope they will help. They aren't to be memorized. Ask us about anything you don't understand. You will find there is really no reason why you should be nervous while testifying. If you relax and remember that you are just talking to some neighbors on the jury, you will get along fine. ◄

Editor's Note: The "Instructions for Witnesses" are of assistance for physicians testifying in court. The original text has been reprinted in full, although some of the suggestions obviously do not apply to physicians testifying as experts.

Reprinted with the permission of *The Practical Lawyer*, 4025 Chestnut Street, Philadelphia, Pa. 19104. Subscription rates: $12 a year, $2 a single issue. "Instructions for Witnesses," by Payne H. Ratner, Jr., 444 North Market, Wichita, Kansas, appeared in the April 1956 issue, Volume 2, Number 4, pp. 44-48.

A maker of eyeglasses has just moved his shop to an island off the coast of Alaska, and is now known as the Optical Aleutian.

Blue Shield Reciprocity Program Expands

THE nation-wide Blue Shield Reciprocity Program expanded substantially when 2.5 million auto industry workers started participating June 1.

The program was first introduced in 1972 to simplify claims handling for Blue Shield members needing medical care away from home.

Under Reciprocity, an Indiana physician files claims with and receives payment from Blue Shield of Indiana for services rendered to out-of-state Blue Shield members enrolled in the program.

Dealing directly with his local Blue Shield Plan enables the physician to use familiar claim forms and speeds reimbursement for medical services.

The physician receives a usual, customary and reasonable allowance for covered services.

Members covered under the Reciprocity Program are easily identified. They carry special Blue Cross and Blue Shield identification cards with a red double-pointed arrow in the top left section. A 3-digit number preceded by the letter "N" appears in the arrow. Among the 2.5 million members covered by Reciprocity are many Indiana Blue Shield members. Their identification card will have "N630" appearing in the double-pointed red arrow. A 3-digit number other than 630 means the member is from another state and his or her claim should be handled according to the Reciprocity program.

To file a claim for professional services provided to those out-of-state patients covered by Blue Shield Reciprocity, the physician's office merely fills out the regular Blue Shield of Indiana claim form adding the appropriate information including the N-numbers from the Reciprocity member's identification card. The claim is filed in the normal manner with Blue Shield of Indiana and the usual payment is received just as if the patient was from Indiana.

Later, Blue Shield of Indiana will "settle up" with the member's own Plan.

There is no change in filing procedure, of course, for out-of-state members who are not eligible for Reciprocity and do not have an identification card with the big, double-pointed red arrow.

It is planned, however, that more and more Blue Cross and Blue Shield members will participate in the Reciprocity Program in the future. ◄



The Woman's Auxiliary Reports to ISMA

Dear Doctor:

I am happy to report that a record number of Medical Association members and Auxiliary members attended the AMA meeting in Chicago June 23rd to 26th. They were willing and active participants at all meetings.

I'm confident you want to know what the Auxiliary members were asked to consider as their programs for the coming year. The following is an outline of the suggestions we received:



(1) AMA-ERF. Continue and expand support.

(2) Legislation. Raise the level of political and legislative awareness.

(3) Health Education. Implement action aimed toward solution of the problem of fragmented and generally inadequate health education in schools and communities throughout the nation, involving school curricula, adult education, coordination of presently available programs, etc.

(4) Family Health
(5) Community Health } Family and community health for identified needs: Emphasize analysis of needs and available help before selecting health projects.

(6) Communications. Promote better communication and visibility with our members, with our physicians' organizations, with the community, with other organizations and with the media.

(7) Membership. Enlist members, then educate to hold them.

In the months to come you will be personally contacted to encourage your wife to become a member, if she has not availed herself of this opportunity. We are most anxious to have a national membership of 90,000 and I would like to see Indiana do its part. With a larger percentage of membership, we can be more effective in carrying out the suggested programs.

Please help me; I want your wife not only to belong, but also to participate in the worthwhile activities of the Auxiliary to **YOUR** medical association.

Warmly,

Beth Bowen

President, Woman's Auxiliary, ISMA



ABSTRACTS, BOOK REVIEWS

HANDBOOK OF POISONING

Robert H. Dreisbach, M.D., Lange Medical Publications, Los Altos, Calif., 1974.

The new edition of Handbook of Poisoning is its eighth, with the first published in 1955. The author, who is Clinical Professor of Environmental Health at the University of Washington and Professor (Emeritus) of Pharmacology at Stanford, describes the purpose of the handbook thus: "To provide a concise summary of the diagnosis and treatment of clinically important poisons." Potentially poisonous agents not important clinically are included in the book in tabular form. This edition incorporates 500 recent references.

After a preliminary section on general considerations, the book discusses poisons in specific areas, such as agriculture, industry, the home, medicine, and finally, animal and plant hazards—such as reptiles, insects, marine animals and plants. There are several pages of illustrations of poisonous fish.

The book is bound in flexible plastic, and is priced at $6.50. This excellent little handbook is recommended for all physicians.

W. D. SNIVELY, Jr., M.D.
Evansville

THE UNCERTAIN MIRACLE, HYPERBARIC OXYGENATION

Vance H. Trimble, Doubleday and Company, Inc., Garden City, N.Y., 1974; 228 pages plus 8-page Directory of Hyperbaric Chambers in the United States, Canada, Mexico and Puerto Rico; $6.95.

The author of this book is "an investigative reporter" who is now editor of the Kentucky Post and Times Star, Covington, Ky. He is a winner of the Pulitzer Prize, the Raymond Clapper Award and the Sigma Delta Chi Award for National Reporting.

The introduction is by Harry J. Alvis, M.D., Submarine Medical Officer, U.S.N., Associate Clinical Professor, School of Medicine, State University of New York at Buffalo, and Consultant, Hyperbaric Medicine, Veterans Administration Hospital and Millard Fillmore Hospital, both at Buffalo. He states:

> Hyperbaric medicine is no "fountain of youth" nor raising from the grave exercise but there is a genuine role for this modality and Vance Trimble has contributed a highly interesting, pleasantly readable account of what the field can do and how it is done.

Be that as it may be, this book is difficult to review without systematic comment on almost every "treatable" entity the author brings forth. I have attempted to evaluate Trimble's claims as to specific conditions from a medical and scientific point of view, but I will accept the history of The Uncertain Miracle without comment, except to say it is most interesting and, in part, even bizarre. This angle is, of course, legitimate grist for the "investigative reporter's" mill.

The hyperbaric chamber has a system of air locks to raise the inside pressure to two or three atmospheres. This increases the partial pressure of oxygen, but also that of nitrogen. In many cases the patient breathes 100% pure oxygen by mask within the pressurized chamber.

As to the physician's side of the picture, available space forbids more than partial listing of medical uses which are on a reasonably solid basis or are claimed to be such, as follows:

1. Hyperbaric oxygen (HBO) is useful in **chronic osteomyelitis,** especially in cases refractory after surgery and antibiotics.

2. **Skin grafts and pedicle flaps.** In a series in England (Perrin), the incidence of take was 95-100% in 17% of controls and 64% in the HBO group.

3. **Diabetic gangrene.** Not proved.

4. **Hyperbaric surgery.** Improvements in heart-lung machines and bypass procedures have largely superseded HBO. Hypothermia works well in infants with congenital heart disease and at this time no new operating chambers are being built for hyperbaric surgery.

5. **Sickle-cell anemia crisis.** As in some other conditions (such as diabetic gangrene), vasoconstriction (due to HBO) must be combatted to obtain good results. (This would be dangerous in case of hematuria.)

6. **Shock.** Success has been reported recently with acute hemolytic crisis. Some have treated Jehovah's Witnesses with good results. On the other hand, many Emergency Room patients have multiple problems, difficult to handle in a one-man hyperbaric chamber.

7. **Gas gangrene.** HBO is highly recommended for clostridial myocytis, but is an *adjunct* to good surgery plus antibiotics.

8. **Tetanus.** No real advantage here, since the toxin, unlike *Clostridium welchii* is fixed in nerve tissue and is not influenced by HBO.

9. **Pulmonary insufficiency.** At the present time the problem of oxygen toxicity is an actual hazard to the patient. Work is in progress to develop drugs to block oxygen toxicity to lungs and brain.

10. **Cerebral edema.** Animal experiments show lowering of intracranial pressure by 50% in five minutes with HBO at three atmospheres absolute. However, there are few places having complete Emergency Room facilities in an HBO chamber.

11. **Myocardial infarction.** Very recent reports from London (Thurston) based on 100 index cases and 100 on standard therapy show that patient selection is the determinant. For instance, a man in the fifth decade with his first coronary and no failure does not benefit from HBO, but a man in late seventh decade with his third coronary and in congestive failure has his chance of survival increased by HBO from 13% to 56%. *(British Quarterly Journal of Medicine.)*

12. **Radiation therapy.** Five-year survival rates are about the same in HBO patients and controls.

13. **Burns.** HBO has been found very useful: it oxygenates cells poorly supplied with oxygen, is bacteriostatic at two atmospheres absolute (to common bacteria), and in a study of burn cases at a naval hospital, fluid requirement was reduced 25%, the eschar separated in half the usual time, graft donor sites healed in 6 days (instead of 10) and hospitalization time was reduced 43%.

14. **Stroke.** About one in six shows dramatic improvement.

15. **Vertigo.** Benefit not certain.

16. **Carbon monoxide poisoning.** HBO is efficient here. Patients with COHgb level of 25% or over should receive HBO.

17. **Cyanide poisoning.** Responds dramatically to HBO. Mechanism unknown.

18. **Air embolism.** HBO is standard treatment.

19. **Decompression sickness.** The original reason for use of recompression.

20. **Actinomycosis.** Responds favorably, but is rarely seen.

21. **Senility.** Response good only when patient has simple arteriosclerosis. Other causes of senile dementia do not respond. Also, a minimum of 60 on the Wechsler Adult Intelligence Scale is a prerequisite. Alcoholics may get worse on HBO. Patients are usually not referred early enough.

22. **Sex and I.Q.** In this field Trimble is a bit enthusiastic, based on pilot studies and much hearsay or anecdotal observations. In several places he admits as much.

It must be remembered that oxygen at high partial pressures produces vasoconstriction, slows metabolism and supports combustion in a high-pressure chamber. Accidents have happened. These may not be all of the side-effects, but they must be considered in any case subjected to HBO. My impression is that this is a field which should be expanded cautiously but, nevertheless, expanded by means of science and integrity. I have no doubt there will be contradictory reports along the way, but the true uses of HBO will appear after there is more basic understanding of all oxygen effects at high pressure.

This book will entertain anyone interested in medical history "in action," so to speak, but the physician's impression will be different from that of the layman.

A. W. CAVINS, M.D.
Terre Haute

CHEMICAL MUTAGENS: PRINCIPLES AND METHODS FOR THEIR DETECTION—VOL. 3

Edited by A. Hollaender aided by a score of biologists, Plenum Press, New York, 1974; $19.50. 300 pages with tables and illustrations; good references.

This is a splendid volume: magnificently accoutred and almost prolix with up-to-the-minute references. There is a splendid review chapter starting with the use of gases in WWI, going on to the use of ionizing radiations, detailing the explication of chromosomes—with the explanation of their aberrations—and then giving pithy summaries of the alkylating agents, nitroso compounds, urethane, alkaloids, inorganic salts, organic peroxides, carcinogens, purines, etc.

The author discusses "Mutagenesis," the need for a register of congenital anomalies which would monitor for possible teratogens in the environment, cancer registries which would overlap with genetic registries, etc. And yet, on page 74, he makes only a passing remark on the infamous thalidomide episode that rocked our world. Have we really progressed to the point where we can predict and so avoid a repetition of such ghastly events? Of course not!

So! Good as this monograph is, let's await hopefully further progress and results crucial to the welfare of all mankind!

ARNOLD LIEBERMAN, M.D.
New York City

MEDICAL RESEARCH SYSTEMS IN EUROPE—

Symposium chaired by G. E. W. Wolstenholme and P. O. Williams, Elsevier, Associated Scientific Publishers, New York, 1973; $14.50; 239 pages of theses and another 80 pages of general discussion; Ciba Foundation Symposium #21.

Each country involved had an able authority give a precis of his country's situation. A snippet of a summary paragraph at the beginning of each thesis was a surprisingly compact summary of what one was to expect. Regrettably, the USSR and Czechoslovakia were conspicuous by the absence of the invited colleagues who had promised to come but were denied last-minute permits to travel to London from their countries.

Rather than go into the details of each country's system, it seems to me that the reader would benefit greatly by simply picking this volume up and perusing it a chapter or so at a time, as time permits. Certainly, our educators would profit enormously by a widened perspective; any M.D. or intelligent lay person would also have his political horizons greatly expanded: especially in view of this precious detente that is being so widely touted!

As usual, the paper, binding and printing are superb. The writers are really terse and very much to the point.

ARNOLD LIEBERMAN, M.D.
New York City

THE UROLOGIC CLINICS OF NORTH AMERICA, VOL. 1, NO. 1

Jack Lapides, M.D., Guest Editor, W. B. Saunders Co., Philadelphia, 1974; $30.00/year.

The "Clinics of North America" are being expanded to include certain surgical subspecialties. This is the first volume devoted to Urology and is entitled "Neurogenic Bladder." The idea to publish newer knowledge in medicine in a hard cover but journalistic format is a good one and indeed the other "Clinics" are famous. I like the "North America" in the title because we in America have indeed been in the vanguard in development of modern urology although the contributors in this initial volume come from Japan, England, Ireland, Denmark and, of course, the United States. The editor, Dr. Jack Lapides, is well chosen and has added significantly to our knowledge relating to bladder function. He invented the operation of vesicostomy, Urecholine test for autonomous bladder, and developed a theory of uninhibited neurogenic bladder to diagnose recurrent urinary infections in many girls and women. His idea that bladder distention causes urinary infection is gaining wide acceptance.

Some essayists, such as Frankel of England's paraplegic center at Stoke-Mandeville, recommend sterile, physician-performed, intermittent catheterization, while Lapides merely has the patient wash the hands and the catheter and pass the catheter without sterile technique. In both instances it works with much less infective morbidity than an indwelling catheter. A whole new body of knowledge regarding catheter use has developed since the 1950's and has gone full circle since Thompson-Walker condemned intermittent catheterization in the preantibiotic year of 1917. These modern concepts are well defined throughout this book.

Two chapters, one on bladder innervation and another on sphincter electromyography by Bradley and associates of Houston are complex and technical and up to date. Many other chapters are clinically oriented. The authors use the classification by function rather than the site of injury and this is easy

to use in medical practice. The various regimens from world spinal cord injury centers are interesting especially to compare similarities and differences.

The drawback here, if there is one, is inherent in the symposium method of developing a scientific treatise. However, the "Urologic Clinics" fill a need in the specialty and I, as a practicing urologist, intend to subscribe and can assemble a small library of correlated newer information by so doing. I commend the Saunders Company and wonder why it took so long.

RODNEY A. MANNION, M.D.
La Porte

CANCER: THE MISGUIDED CELL

David M. Prescott—Pegasus, a division of Bobbs-Merrill Co., Inc., Indianapolis, 1973; $6.95; 186 pages with numerous diagrams and illustrations.

In his half-dozen years as professor of developmental biology at the University of Colorado, Dr. Prescott has put to good use his didactic talents. In about the simplest and clearest possible language, he traces the "cellular basis of cancer," its unique nature, the progress in basic research and correlates all this with the cellular basis of life.

Then, he analyzes the nature of cell growth, how the cell prepares for cell division, the specific character of chromosomes, how they divide to provide the crucial specificity of the daughter cells, etc. Then (on page 53), he presents diagramatically the cell life cycle starting with the division period, then having the GAP—G-1—period followed by the S period (synthesis). We are given then the G-2 period which leads again to cell division.

There is a clear presentation of the evidence for the fact that the *virus* can be oncogenic by either fragmenting an already present chromosome or else by incorporating itself into the chromosomal pattern.

Then, we are given concise statements on chemical and radiation carcinogens, all of which "produce their effects by causing the loss of the proper function of one or more regulatory genes in the cell" (page 163).

This little booklet is a real tour de force! I can only congratulate the author on his pedagogic skill! The paper, binding and printing are excellent and the price well within reason.

ARNOLD LIEBERMAN, M.D.
New York City

OPPORTUNISTIC PATHOGENS

Edited by J. E. Prier and Herman Friedman, University Park Press, Baltimore, 1974; $14.50; 300 pages; proceedings of the Fourth Annual Symposium of the Microbiological Society.

The usual couple-dozen participants give us a fresh insight into an important and yet too-often neglected aspect of the practice of medicine. How often we forget that "the mechanism of superinfection was suppression of the normal flora." And: where do the gram negative opportunists fit into the picture? Gram negative septic shock is certainly a real disaster, if ever there is such a thing.

The discussion on the yeasts of medical importance is an example of what this volume is all about. The serodiagnosis of the opportunistic mycoses is really thought-provoking. Their exact identification; contaminant or really present? Toxoplasmosis and pneumocytosis; what happens when the hosts are immunocompetent or compromised?

One could go on and on, but this should suffice. Certainly, the laboratoreis should have all their personnel leaf through this monograph. The practicing M.D. does not have to have the details but should have the benefit of being told what can be expected in a specific case. All in all, a most worthy effort!

As usual, the printing, binding and paper are superb. A most commendable effort all around!

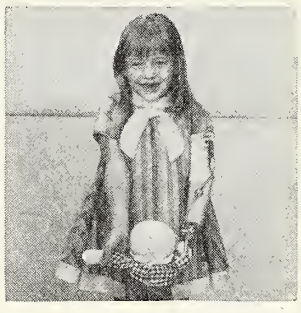
ARNOLD LIEBERMAN, M.D.
New York City

METHODOLOGICAL APPROACHES TO THE STUDY OF THE BRAIN NUTRITION AND ITS ABNORMALITIES

Proceedings of 1971 Symposium held at NISHD, Rose F. Kennedy Center, Edited by D. P. Purpura, M.D., and Georgia P. Reaser, M.D., University Park Press, Baltimore, 1974; 150 pages; $12.50.

While this volume states that the score and more participants tried to delve into the biochemistry of brain maturation abnormalities, actually the authors uniformly use the simplest language and stay on the medical student or paramedical personnel level of understanding. I do believe that an intelligent lay person would be able to comprehend the contents. If the reader would care to glance at my review on "Macromolecules and Behavior" (*JISMA* Feb. 1974), the point would be clear.

The four sessions were divided into: Studies of Simple Neuronal Systems, Neurochemistry of Brain Maturation, Morphophysiological Studies of Brain Maturation and Development



The value of early fitting

Research has proven the fitting of prostheses on children should be accomplished as early as is practicable. It has only been a few years since the child amputee was not considered ready until just before pre-school age or even later. Extensive experience demonstrates that fitting at a much earlier age produces more effective results.

If there are no complicating factors, children with arm amputations usually should be provided with a passive type of prosthesis soon after they are able to sit alone, generally at about six months of age. Lower-extremity child amputees should be fitted with prostheses as soon as they show signs of wanting to stand. The development of muscular coordination of child amputees is the same as for non-handicapped children; and, therefore, this phase may take place as early as eight months or as late as 20 or more months.

For more information, please write to:

Hanger PROSTHESES

1332 N. Illinois St., Indianapolis, Indiana 46202
312 E. McMillan St., Cincinnati, Ohio 45219
416 N. Main Street, Evansville, Indiana 47711
3004 S. Wayne Ave., Fort Wayne, Ind. 46807

of Cognitive Functions. In his most perceptive foreword, Dr. Dominick Purpura closes with: "A redefinition of purposes, methods and procedures may serve to catalyze a host of reactions, not the least of which may be the recognition that stimulus-bound behavior prejudices us in favor of our own precious methodological approaches."

Need more be said?

ARNOLD LIEBERMAN, M.D.
New York City

Abstracts from Various Literature, Prepared by AMA

STUDY OF HEPATIC DISEASE IN AUSTRALIA ANTIGEN AND ANTIBODY-POSITIVE BLOOD DONORS

R. I. Russell et al. (Royal Infirmary, Glasgow, Scotland)
Am. J. Dig. Dis. 19:113-121 (Feb.) 1974

Thirty-nine blood donors, found on routine testing to be Australia antigen (HB-Ag) or antibody (HB-Ab) positive, were studied for evidence of hepatic disease. Seven had severe and five had minor biochemical abnormalities; eight of these 12 subjects had HB-Ag and four had HB-Ab; four had raised serum cholesterol levels but no other biochemical abnormalities; 23 subjects had normal biochemistry. Of 11 subjects who underwent hepatic biopsy, three were found to have evidence of chronic persistent hepatitis. Two of these three had HB-Ag and one had HB-Ab. Minor histological abnormalities were found in a further five subjects. Biopsies were done on five subjects with normal biochemistry, and one of these was found to have chronic persistent hepatitis. Subjects with persistently positive tests for HB-Ag or HB-Ab may have chronic hepatic disease.

TREATMENT OF HYPERTENSION WITH PROPRANOLOL

Y. Traub et al. (Dept. of Internal Medicine, Beilinson Hosp., Tel Aviv, Israel)
Harefuah 86: 124-127 (Feb. 1) 1974

The effect of propranolol as the sole therapeutic agent was investigated in 44 hypertensive patients. There were three study periods (run-in, placebo and final) of eight weeks each. Eight patients were excluded during the run-in period because of side effects or noncooperation, as well as one patient with pheochromocytoma. In 26 patients, a very significant ($P<0.0005$) reduction of blood pressure was obtained with propranolol in daily doses of 120 to 960 mg. Nine patients did not respond to treatment despite daily doses of 960 mg.

NEW DEVICE FOR MANAGEMENT OF POST-NASAL EPISTAXIS BY BALLOON TAMPONADE

M. Bell et al. (100 College St. Toronto)
Arch. Otolaryngol. 99:372-374 (May) 1974

Posterior epistaxis may be managed by tamponade using a Foley balloon-type catheter in place of conventional posterior packing. The efficacy of this method depends on exerting constant forward traction on the catheter in order to firmly anchor the balloon in the posterior nasal cavity. The complications of postnasal balloon tamponade usually involve trauma to the external nose, which is the conventional site of fixation of the catheter. A simple tripod facemask, easily constructed from flexible aluminum finger splinting material, provides superior traction and fixation for the Foley catheter.

SILENT MATERNAL TRANSMISSION OF AUSTRALIA ANTIGEN

S. Mazzur et al. (Institute for Cancer Research, Fox Chase Center for Cancer and Medical Sciences, Philadelphia 19111)
Nature 247:38-40 (Jan 4) 1974

Chronic asymptomatic carriers of Australia antigen are found in human populations throughout the world and they constitute an important reservoir for maintenance of the infectious agent. The establishment of these carriers is through the silent transmission of chronic infections from generation to generation through the maternal line.

SODIUM RETENTION ACCOMPANYING INSULIN TREATMENT OF DIABETES MELLITUS

C.D. Saudek et al. (818 Harrison, Boston 02188)
Diabetes 23:240-246 (March) 1974

Five diabetics with varying degrees of decompensation were hospitalized in a metabolic ward. Prior to the initiation of insulin therapy, urinary sodium excretion was measured while sodium intake was regulated. Insulin therapy induced the expected fall in plasma glucose, free fatty acids and ketones, but in addition caused a striking change in urinary sodium excretion even though sodium intake was kept constant. The antinatriuretic effect of insulin could not be accounted for solely by the reduced glucosuria or ketonuria. Insulin's antinatriuretic effect warrants consideration when treating patients with cardiac or renal failure.

LIVER FUNCTION IN WORKERS HAVING HIGH TISSUE STORES OF CHLORINATED HYDROCARBON PESTICIDES

D. P. Morgan (Institute of Agricultural Medicine, Univ. of Iowa, Iowa City 52319) and C. C. Roan
Arch. Environ. Health 29:14-17 (July) 1974.

Five serum enzyme activities and urinary D-glucaric acid excretion were measured in 56 controls and 71 pesticide-exposed subjects to determine whether workers with large tissue stores of DDT and dieldrin show signs of liver cell injury or induction of drug-metabolizing enzymes. Although serum concentrations of these chlorinated hydrocarbons in many workers exceeded by far those found in persons not occupationally exposed to pesticides, only small, equivocal differences in serum enzyme activities were observed. Urinary excretion of D-glucaric acid was unrelated to serum concentrations of either DDT, DDE, or dieldrin.

FUTURE MEETINGS, SEMINARS, COURSES

"Sports Medicine" Course Set

Indiana University School of Medicine, Division of Postgraduate and Continuing Medical Education, announces its first short course of the coming year's schedule. An orthopaedics course emphasizing diagnosis and acute care of athletic injuries and to discuss the timing of returning to competition is set for Wednesday, Aug. 28. The course will be held at the Medical Center Campus.

For further information contact: Division of Postgraduate Medical Education, IUMC, 1100 W. Michigan St., Indianapolis 46202.

Congress of Electromyography To Meet

The Fifth International Congress of Electromyography will be held at the Mayo Clinic, Rochester, Minn., Sept. 21-24. The American Association of Electromyography and Electrodiagnosis will be the host society.

ACP To Sponsor Course at Indianapolis

One of the postgraduate courses of the American College of Physicians entitled "Selected Topics in Endocrinology and Metabolism" will be conducted in Indianapolis September 11 to 13. The course is being planned under the direction of Dr. C. Conrad Johnson, Indianapolis.

Continuing Education Workshops Set

The Illinois Council on Continuing Medical Education plans two workshops designed for hospital DME's and also for CME planners. One will be held at the Oak Brook Hyatt House (Chicago) and the other at the Marriott Inn near Lambert Field in St. Louis. Both will meet from 7 p.m., Friday, October 4, to noon Sunday, October 6. The subjects will include—Effective methods for involving physicians in planning and conducting in-hospital CME programs; Group techniques for problem-solving; and Methods for analyzing learning needs of hospital physicians. Registration is limited. For details write the Council at 360 N. Michigan Ave., Chicago 60601.

Interstate Scientific Assembly: Nov. 3-7

The 59th Annual International Scientific Assembly of Interstate Postgraduate Medical Assn. will be held at The Diplomat Hotel and Resort, Hollywood, Florida, Nov. 3-7. This program, designed chiefly for Primary Physicians in the U.S. and Canada, has been planned cooperatively with the Florida Academy of Family Practice and the University of Miami School of Medicine. It will provide 26 hours of *prescribed credit* for A.A.F.P. members who attend.

The Assembly is open to any licensed M.D. in the U.S. or Canada at a fee of $35 in advance or $50 at the meeting. Those interested in full details of the meeting and hotel forms should write to: Alton Ochsner, M.D., Program Chairman, Interstate Postgraduate Medical Ass'n, P.O. Box 1109, Madison, Wis. 53701.

Mexico to Host World Conference

The Sixth World Conference on General Practice-Family Medicine will be conducted in Mexico City November 4 to 8. For particulars write to Dr. Oscar Bravo Serradel, Avenida Cuauhtemoc 330, Mexico 7, D.F.

Cosponsor Course on Computer Use

A National Conference on Legal Aspects of Computer Use in Health Care Delivery will be held November 7 and 8 in Boston under the sponsorship of the American Society of Law and Medicine and Blue Shield of Massachusetts. The program is approved for 15 hours toward the Physician's Recognition Award. Application has been made to American Academy of Family Practice for accreditation for 15 elective hours. Full details may be obtained by writing American Society of Law and Medicine, 454 Brookline Ave., Boston 02215.

"Drugs in the Newborn" Symposium Set

The Department of Pediatrics, University of Louisville School of Medicine, presents its Eighth Annual Newborn Symposium, November 7 and 8, 1974, to be held at the Health Sciences Center Auditorium, Louisville, Ky. Participants will be: Drs. Virginia Apgar, Audrey K. Brown, William C. Heird, Mildred T. Stahlman, James M. Sutherland, Joseph J. Volpe, Sumner J. Yaffe and members of the Department of Pediatrics, University of Louisville School of Medicine.

Dr. Virginia Apgar will deliver the 1974 Tenth Annual Louisville Pediatric Lecture on November 6.

For information write: Dr. Billy F. Andrews, 200 East Chestnut Street, Louisville, Ky. 40202.

Cancer Chemotherapy Conference Scheduled at Houston Nov. 7-9

"Cancer Chemotherapy: Important Advances and Recent Developments" will be the subject of the 19th Annual Clinical Conference November 7 to 9 at the Shamrock Hilton Hotel in Houston. As a part of the Conference, the 7th Annual Special Pathology Program will be held on November 9 to "Review Cases Illustrating Pathologic Changes Produced in Cancer Patients Receiving Chemotherapy." For additional information write Mrs. Jane Brandenberger, M.D. Anderson Hospital, Houston 77025.

Workshop Scheduled at Chicago

Authorities on Nurse Practitioners, Physician's Assistants, Surgical Assistants and Emergency Medical Technicians will conduct a full-day workshop in the Sheraton-Blackstone Hotel,

Chicago, on Friday, Nov. 15, under the title "New Health Practitioners—Partners in Patient Care." The faculty includes Dr. Malcolm Todd, president of the AMA, and Dr. Raymond H. Murray of Indiana University. The registration fee, which includes lunch, is $20. To register write the Institute of Medicine of Chicago, 332 S. Michigan Ave., Chicago 60605.

Eye and Ear Infirmary Announces Course

The Department of Otolaryngology, Abraham Lincoln School of Medicine, University of Illinois, and the Eye and Ear Infirmary of the University of Illinois Hospital, will conduct a continuing education course in Laryngology and Bronchoesophagology November 18 to 23, 1974. The course is limited to twenty physicians and will be under the direction of Paul H. Holinger, M.D. It will be held largely at the Eye and Ear Infirmary, 1855 West Taylor Street, Chicago, and will include visits to a number of other Chicago hospitals. Instruction will be provided by means of animal demonstrations and practice in bronchoscopy and esophagoscopy, diagnostic and surgical clinics, as well as didactic lectures.

Interested physicians will please write to the Department of Otolaryngology, Eye and Ear Infirmary, 1855 West Taylor St., Chicago 60612

Courses at Ann Arbor Listed

The University of Michigan Medical Center (Towsley Center for Continuing Medical Education), Ann Arbor, has announced the following postgraduate medicine courses planned for this fall.

Sept. 24-26	Blood Coagulation Techniques
Oct. 2	Illness in Children (for Social Workers)
Oct. 8-10	Cardiology for Internists
Nov. 8-9	Advanced Burn Care
Nov. 13	Medicine and Law: Trends and Protections
Nov. 15-16	Anesthesiology Conference
Dec. 4	Cardiology for Family Physicians (MAFP)*
Dec. 6	Basic Burn Care

*Co-sponsored with the Michigan Academy of Family Physicians

All courses will be held at the Towsley Center in Ann Arbor. Inquiries should be addressed to: Office of Intramural Education, Towsley Center, U.M.M.C., Ann Arbor, MI 48104.

Cleveland Clinic Announces 1974-75 PG Course Schedule

Postgraduate courses to be given at the Cleveland Clinic during the coming academic year have been announced and are as follows:

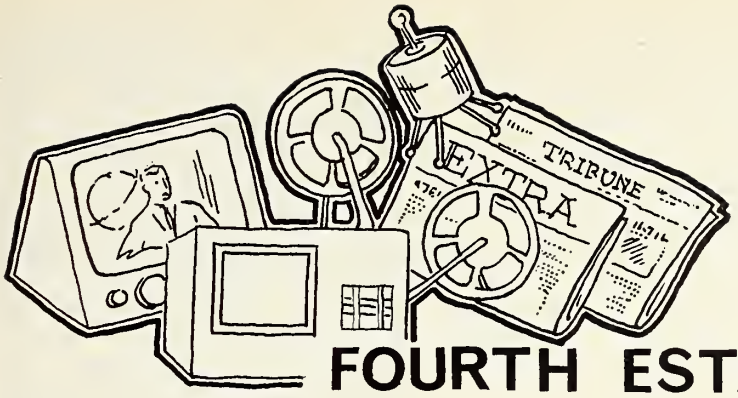
Medical Technology, Sept. 19
Current Concepts in Renal Disease and Hypertension, Oct. 9 and 10
Myocardial Revascularization Surgery, 1974: Selection of Patients, Pitfalls and Postoperative Results, Oct. 16 and 17
Gastroenterology: Clinical Problems, Nov. 20 and 21
Perspectives in Ophthalmology, Dec. 4 and 5
Controversies in Surgery, Jan. 15 and 16
Medical Progress for the Family Physician, Jan. 29 and 30
Sports Medicine, Feb. 5 and 6
Pressures in Anesthesiology, Feb. 7, 8 and 9
Special Topics in Rheumatic Disease, Feb. 19 and 20
Blood Bank Management, Feb. 26 and 27
Advances in Urology, Mar. 5 and 6
Medical Progress and Its Relationship to Dentistry, Mar. 12 and 13
Recent Progress in Clinical Cancer, Mar. 19 and 20
Practical Neurology, Apr. 2 and 3
Refresher Seminar in Pediatrics for Pediatricians and General Practitioners, Apr. 9 and 10
Diagnostic Immunology, Apr. 23 and 24
New Advances in Dermatology, May 15 and 16

These programs in continuing medical education are accredited by the AMA and are acceptable for Category 1 credit toward the AMA Physician's Recognition Award.

For further information and detailed programs write to the Director of Education, The Cleveland Clinic Foundation, 9500 Euclid Ave., Cleveland, Ohio 44106.

Indiana Medical Foundation

The Indiana Medical Foundation was organized to furnish support for the educational activities of the Indiana State Medical Association. These activities include programs for continuing education and the scientific publications of The Journal. Contributions made to the foundation are deductible by donors in accordance with the Internal Revenue Code. Bequests, legacies and gifts are deductible for federal estate and gift tax purposes. Memorial contributions made to the foundation will be formally recorded and acknowledgment will be sent to the family. Gifts, bequests, and memorial contributions may be mailed to the foundation at 3935 N. Meridian St., Indianapolis 46208.



FOURTH ESTATE

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

It's Worth Thinking About

One physician says that if a national health plan is enacted, cigarette smokers should foot the bill for all medical expenses stemming from smoking-related diseases—to the tune of $11.5 billion.

The doctor figures that is almost 20% of the money now spent on health care in the United States.

"It's wrong for nonsmokers to pay medical bills caused by smokers," said Dr. Stephen M. Ayres.

"About $11.5 billion of the $60 billion spent for health care in this country is due to smoking cigarettes," he said. "If we're going to sink $60 billion into a national health program, then a proportionate amount should be paid by the smokers."

Ayres, chief of medicine at St. Vincent Hospital in Worcester, Mass., made his proposal at the American Lung Association's annual meeting in Cincinnati.

The convention, which attracted 2,500 doctors and other health workers from around the country, winds up today.

"I'm for a national health program, but I want it to be financed fairly," said Ayres.

"For instance, a formula should be worked out to determine the amount of tax on each pack of cigarettes sold so the $11.5 billion medical bill caused by smokers can be paid by smokers—not nonsmokers."

Ayres said he didn't know how much the price of each pack of cigarettes might jump to.

Ayres likened buying cigarettes throughout one's lifetime to buying cancer.

"It's possible to buy a case of cancer at any cigar store for $3,750," he said. "But the treatment costs $30,000." — *The Martinsville Daily Reporter,* May 15, 1974.

Man Of Medicine

The achievement of a half-century of productive and rewarding work in a career is relatively uncommon. At the age of 83, Dr. James O. Ritchey has done that and then some, and has earned many honors along the way.

A former president of the staff of Methodist Hospital, he has been on that staff for 50 years, a longevity of continuous service shared by only one other doctor. He had opened his medical practice three years before joining the Methodist staff, after two years of residency at Robert W. Long Hospital. And before that he had taught school for five years.

Later he taught medicine at Indiana University and was chairman of its Department of Internal Medicine for a quarter-century.

Practictioner and teacher, he also continued to be a student. For his contributions to the advancement of internal medicine he has been honored by the university, Methodist Hospital and the American College of Physicians, which elected him a master three years ago.

Today is the fourth annual Ritchey Recognition Day at Methodist Hospital. In a demanding profession, he has set many marks of high distinction. — *The Indianapolis Star,* Apr. 10, 1974.

An Idea That Worked

An idea that worked, and has continued to work is the Indiana system of statewide medical education.

The problem was a shortage of doctors. The usual response is to build a new medical school. The drawbacks were that a new medical school absorbs more doctors than it turns out for the first 10 or 15 years and that state institutions of higher learning could not agree who would get the school.

So a careful study indicated the possibility of spreading medical training around the state, at hospitals and at regional campuses. Postgraduate education was another problem area; too many Indiana graduates left the state to continue their education elsewhere.

In coordination with the regional medical school, the state legislature increased support for internships and residencies among newly graduated doctors.

That move has nearly doubled the number of doctors continuing their education in the state.

One index of the success of the program is that in Indiana the doctor-to-patient ratio has increased from 98 to 100,000 in 1967 to 105 to 100,000 in 1972.

Had the state legislature voted in 1967 to build a new medical school, it would have cost about $150 mil-

lion and would still be three or four years away from getting its first graduates into practice.

It amounts to an instructive example of how thinking about the problem yields a good solution. The alternative was throwing money at the problem with results that hardly bear thinking about.

Hopefully Jay County will be equally careful with as good results in dealing with the local hospital's problem. — *Portland Commercial-Review,* May 28, 1974.

Lowering Infant Mortality

The United States has had a high infant mortality rate compared with other countries, but that situation is rapidly being corrected.

Thanks to the cooperative effort of the Riley hospital for children, state police, and physicians throughout the state, there are many children alive today who would have been dead if they had been born 10 years ago.

The recent cases of two Winamac infants being flown to Riley hospital's intensive care unit in a state police helicopter was an excellent example of the battle that is being waged to save the lives of desperately sick infants.

When an Indiana physician determines that a newborn child needs specialized care, he can call the staff of the Riley hospital intensive care unit on the emergency "hot line" to obtain advice on what to do. Then the infant can be flown by state police helicopter to Riley for treatment by a specially trained team of doctors and nurses.

Dr. Edwin Gresham, chief of perinatal medicine at Riley, says his goal is to decrease the number of newborn deaths by two thirds and the stillborn deaths by half. He seems to be well on the way toward achieving that goal. — *Pharos Tribune and Press,* Logansport, Apr. 7, 1974.

The Need For Confidentiality

The issue of confidentiality of patient records is an extremely complex one. Today it is being further complicated by the increasing use and reliance on electronic data processing equipment.

From a clinical viewpoint, the confidential relationship between the physician and patient is extremely important.

The patient must feel that he can be perfectly honest with his physician so that effective treatment can be provided.

During the AMA Clinical Meeting in Anaheim, the matter of confidentiality was the subject of a report of the Council on Medical Service and three resolutions.

After considerable discussion, the report and one of the resolutions was adopted in lieu of the other two resolutions. One of the latter resolutions placed very strict restrictions on how carriers obtained information, and would have placed an unnecessary and expensive administrative burden on carriers. The House wisely did not adopt it as AMA policy.

But the discussion did point out the need for Blue Shield to constantly strengthen Plan procedures to assure the security of confidential information on a regular basis.

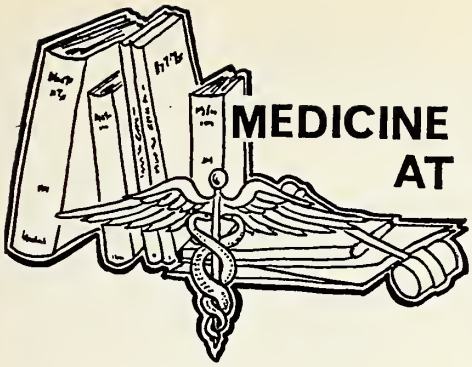
The Council has proposed a set of guidelines on confidentiality, and they include the following which are of relevance to Blue Shield:

> Emphasize to claims personnel the necessity for preserving the confidentiality of medical information.
>
> Instruct all personnel having access to patient medical information not to divulge that information to the patient or his employer under any circumstance.
>
> Discourage the practice of indiscriminate photocopying of physician's records.
>
> Encourage claims examiners, when requesting additional information from physicians for purposes of claims processing, to be specific as to their needs.

By reminding Plan employees again of the need to follow these rules closely, Blue Shield can best serve subscribers and the medical profession. — *The Blue Shield,* December 1973.

About Our Cover

We are indebted to **Outdoor Indiana,** its editor, Herbert R. Hill, and its photography staff for permission to reproduce the woodland scene in Mounds State Park at Anderson, one of our lesser known but historically significant state parks.



MEDICINE AT LAW

Damages Denied for Drug Injuries—In a suit against a physician and a drug company, a patient who suffered injuries after treatment with a drug was denied recovery of damages by a California jury.

A physician gave the patient methotrexate for treatment of psoriasis. As a result of taking the drug, he suffered portal cirrhosis of the liver and esophageal varices.

The patient sued the physician for malpractice, contending that methotrexate was not approved or recommended for use in treating psoriasis. He also sued the drug manufacturer, contending that it knowingly sold the drug for treatment of psoriasis in spite of lack of approval by the Food and Drug Administration.

The physician said that he followed the standard of care in the community. The drug company contended that it had no control over the physician's use of the drug. The verdict for the physician and the drug company was unanimous.—*Kowalski v. Rees* (Cal.Super.Ct., San Francisco Co., Docket No. 609709, Jan. 9, 1974).

Labeling Arthritis Cure "Quack" Held Not Libelous—In an action for libel, statements labeling a health mine as a "quack" cure for arthritis were privileged because a significant portion of the population was afflicted with arthritis and treatments and cures for it were matters of public interest, a federal trial court in Montana ruled.

A monthly magazine of nationwide circulation published an article which contained the following paragraph:

> "Promoters of quack 'cures' have become unspeakably bold. In Boulder, Montana, there is an abandoned uranium mine whose glowing advertisements lure thousands each year to soak up radon, a radioactive gas, in hopes of relieving their pain. The AMA has called this type of treatment not only useless, but potentially dangerous. Nevertheless, when news accounts reported that the famous heart-transplant pioneer, Dr. Christiaan Barnard, had arthritis in his hands, the mine owner actually sent him a brochure and invited him to take the cure!"

The owner and operator of the health mine alleged that the article contained false, willfully malicious, and unprivileged statements about them and brought a libel action against the publisher of the magazine.

U.S. Supreme Court decisions have extended the privilege of First Amendment immunity from public officials to matters of public interest and concern, the court pointed out. Noting that many people suffered from arthritis, the court said that treatments and cures were a matter of public interest and concern.

The publisher had documented its claim that it did not print the article with actual malice. The federal trial court dismissed the case on the grounds that the article was privileged and no actual malice was shown.—*Lewis v. Reader's Digest Association, Inc.*, 366 F.Supp. 154 (D.C., Mont., Nov. 5, 1973).

Internal Hospital Report Must Be Produced in Malpractice Suit—A report prepared by a hospital for use at a hearing on its refusal to grant a physician permanent staff privileges had to be produced in a malpractice suit against the physician and the hospital, the highest court of Kentucky ruled.

Claiming that the hospital knew or should have known that the physician was incompetent, a patient brought a negligence action against the hospital and a malpractice suit against the physician. The physician had only temporary privileges at the hospital, and the hospital later decided to refuse to grant him permanent staff privileges.

The physician was entitled to a hearing before the hospital board and, in anticipation of that hearing, the hospital had obtained statements and reports of other staff physicians. At the trial, the court directed the hospital to produce those reports, stating that, if it did not, default judgment would be entered against it. The hospital obtained a temporary order prohibiting the court from enforcing its order.

After a hearing on the merits of the prohibition order, the court dissolved its temporary prohibition order and denied a permanent one. The hospital argued that its report was like the work product of a lawyer and that the material should remain privileged because of public policy considerations.

Stating that the records were not gathered as part of a lawyer's file in anticipation of a lawsuit, the court rejected the analogy to a lawyer's work product. Furthermore, the court said, it was a recognized rule that documents prepared for one case are not protected from discovery in another case in which they were relevant.

As to the public policy argument, the court relied on a California case where a trial court held that a patient who sued a physician for medical malpractice was entitled to obtain all hospital records of the physician's disciplinary proceedings and removal from the hospital staff. Noting that the hospital might be

able to obtain an order limiting the extent of the hospital records which had to be produced, the court dissolved the temporary injunction and denied a permanent one.—*Nazareth Literary and Benevolent Institution v. Stephenson,* 503 S.W.2d 177 (Ky. Ct. of App., Dec. 7, 1973).

Blood Grouping Test Used to Deny Child Support In Divorce Case—In a divorce action, a blood grouping test which proved that a husband could not have fathered his wife's child was properly admissible, an Indiana appellate court ruled.

After a trial court ordered the husband to pay support for his estranged wife and her child, the husband denied that he was the father of the child.

After a hearing was held, the court granted a divorce and found that the husband was not the father of his wife's child and was not liable for the child's support. The wife appealed.

Noting that the question of admissibility of blood tests in a divorce action had never been decided in Indiana, the apellate court said that a court rule indirectly supported admission of blood tests to determine paternity. The blood tests had been conducted by a qualified expert, and they excluded the husband as the father of the child.

Admissibility of blood grouping tests is the prevailing view, the appellate court said. Medical science has perfected the blood tests to the point where it can be said with medical certainty that someone is not the father of a child. Therefore, the court should not hide in the dark ages and subvert justice, the appellate court said.

Along with the results of the blood tests, the husband's testimony that he had not had sexual relations with his wife during the period of conception, and testimony that the wife had traveled to another town with another man and had been seen in taverns with other men, constituted clear evidence that the husband was not the father of his wife's child. The blood test results were properly admissible to rebut the presumption of paternity, and the trial court's determination was affirmed. —*Beck v. Beck,* 304 N.E.2d 541 (Ind. Ct. of App., Dec. 19, 1973).

Medical Panorama

Financial Control in the Hands of Third Parties

A. W. CAVINS, M.D.
Terre Haute

CONTROL, control, control —of the medical profession. It approaches us from many angles and in many guises. Usually, the wolf stalks us in sheep's clothing, and an example of this is the so-called "medical foundation."

The *Massachusetts Physician* for June 1974, vol. 33, no. 6, presents an editorial which lifts the disguise to show the "wolf" beneath. Extracts from this appear below. The last paragraph contains a sentence which epitomizes the entrapment of free men by means of financial control in the hands of third parties. Here is the sentence: "Once the ideological sense of obligation has developed, rational debate of the issues will become impossible." Do read the following:

The Foundation Flimflam

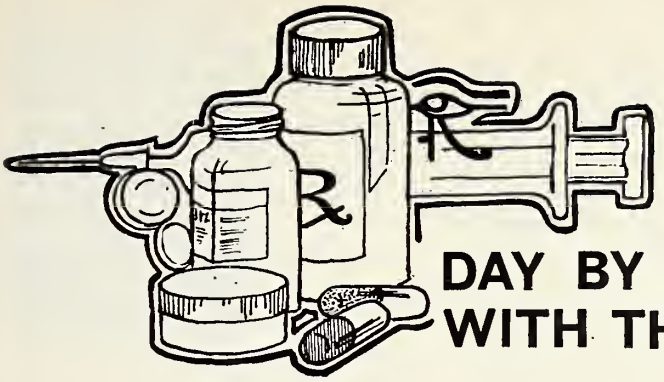
The domination of medical foundations by third parties, such as Blue Shield, the state and federal government, and commercial insurance carriers, has become increasingly apparent. During the late 1960's physicians who had become confused and threatened by discussion of a national health system sought means of preserving the traditional private practice mode through the medical foundations.

The original impetus for the "foundation movement" came from the Health Insurance Council, which noted the potential for cost containment and dignified the physicians' assumption of a bureaucratic role with the appellation of "statesmanship in medicine."

Rather than serving to protect the physician-patient relationship from third party control, the foundation for medical care has become an instrument by which such control is being imposed. Large sums of money, such as the $1,750,000 being paid by the Massachusetts Medicaid Program to the Commonwealth Institute of Medicine (CIM) and the Bay Sate Foundation for operation of the Commonwealth Hospital Admissions Monitoring Program (CHAMP), and the granting of $109,000 by the Tri-State Regional Medical Program to CIM for statistical analysis related to the CHAMP program, serve as the financial cord with which the knot of obligation is tied. The application by foundations for designation as PSRO's further deepens their commitment to governmental objectives.

The continuing independence of the Massachusetts Medical Society and its member physicians from authoritarian third party control will depend on our alert analysis of the consequences of our capture by foundations. A proliferation of agencies, spawned by the Medical Society, which seek to bind physicians by contract to third party influence, poses the ultimate threat to our relationships with our patients.

Once the ideological sense of obligation has developed, rational debate of the issues will become impossible. Because of the inherent danger they pose to our personal and professional freedom, *Massachusetts Physician* advises MD's to reject participation in the foundation flimflam. ◄



DAY BY DAY WITH THE F.D.A.

The finding of botulinum toxin Type B in one 8-ounce can of mushrooms caused the producer voluntarily to recall all its products from commercial channels. The recall extended to the retail and restaurant level, including all lots of all styles. Indiana State Board of Health inspectors aided by conducting effectiveness checks.

* * *

The FDA and six consumer agencies from Lake County, Indiana, recently sponsored a "Consumer Dialogue" in Gary for a free exchange of information. One of the agencies was the Latin American Family Council, which was addressed by the District Inspector in Spanish.

* * *

The FDA is inspecting food plants near Duluth to determine whether the city water is contributing asbestos fibers to food products. A mining company dumps taconite tailings into Lake Superior at the rate of 67,000 tons daily. Taconite tailings are about 20% asbestos fibers. Duluth city water contains 1000 times the amount of asbestos ever found previously in drinking water supplies. Tests are being conducted to determine whether waterborne asbestos is dangerous.

* * *

Save-A-Life Emergency Oxygen was found by FDA to be inaccurately named. The devices were condemned in Pennsylvania when they were found to be inadequate for the purpose. FDA said that the only dependable action of the gadgets was to delay proper emergency treatment.

* * *

FDA received a complaint from a consumer who said that a can of tuna she bought actually looked like cat food. When the code number was investigated, sure enough, cat food it was. This started another investigation at the canning plant.

* * *

More than 15,000 Majzlin Spring intrauterine devices were seized by FDA in the New York District. Complications such as cramps, bleeding, perforation of uterine wall and imbedding in uterine wall are the basis of disapproval.

* * *

State authorities from Indiana and Ohio have been cooperating in solving a problem of pesticides found in milk tested in a dairy in Cincinnati. Two Indiana dairy farms were determined to be the source of the contamination. Both milk producers were monitored carefully until pesticide residues were eliminated.

* * *

Three instances of acute food poisoning in Little Rock, Ark., within a four-day period, proved to be due to *Salmonella*. At least 190 persons became ill. Microbe detective work traced the cause to a catering firm and its barbecued beef. Several isolated cases were then found among other customers who had partaken of the same lot of beef over the 10 days prior to the epidemic.

* * *

A dairy in Massachusetts was fined for using gasoline-contaminated plastic bottles for milk. It is theorized that some customers had used milk bottles for temporary gasoline containers and had returned them to the dairy. Normal washing does not remove gasoline or kerosene odors from this particular plastic.

* * *

A New York firm destroyed 3,278 pounds of its "Delila Smoothee Leg Lotion" when it was found that the entire lot was heavily contaminated with *Pseudomonas*.

* * *

An airline catering service in Puerto Rico was found to be insanitary and was decertified pending a clean-up. After two more inspections the service was satisfactory. Soon after this plane landed in Puerto Rico with sick passengers. The same catering service had supplied the plane from its Lisbon kitchen. Coagulase-positive staph *aureus* in the gelatin and the cream dessert.

* * *

The FDA is accused of slowing up the discovery and release of new drugs. This is, at least, partially correct. A lot of drugs arrived at Honolulu from the Peoples Republic of China recently. FDA detained the shipment when it found that all the drugs were patent medicines without New Drug Applications. Some contained known therapeutic agents but one, powdered antelope horn, was considered as unknown. We will have to muddle along without it.

* * *

Dried figs from Turkey were found in New York to contain excessive residues of aflatoxin, a carcinogenic substance produced by the mold *Aspergillus flavus*. This is the first time aflatoxin has been identified in figs. Other shipments have been O.K. All shipments will be tested in the future.

* * *

Oregon will have a regulation against labeling any salt product as "sea salt." Chemical analysis shows that true sea salt and ordinary table salt are practically identical.

* * *

Falsification of results of drug testing is a serious offense. A physician pleaded nolo contendere to such a charge when the FDA questioned his findings. A suspended prison sentence and a refund of the contract fees was the result.

* * *

Fifty tons of oats, contaminated with mercury, were destroyed by burial in Minnesota after all plans for salvage had been found to be too expensive and a plan to spread the grain on cropland was nixed because of hazard to game birds.

* * *

Organically grown food has become so popular and its certification so difficult that regulations are necessary to govern labeling. Right off, the first rule is that any animal product or byproduct cannot be labeled as organically grown because animals and bees are so mobile that their background and the chemicals to which they are exposed cannot be determined.

* * *

Mushrooms are in the category of low-acid canned foods and, if improperly preserved or canned, are conducive to the growth of spores of botulism. 337 lots of imported mushrooms, valued at over $1¼ million, have been checked by FDA.

* * *

Getting the correct label on a pharmaceutical product is as important as anything else that is done to make the drug reliable. A recent finding of a vial of Procaine in a carton labeled "Sodium Chloride" was due to the fact that the company's printing shop had printed the two types of carton labels one after the other on the same day.

* * *

FDA has a mobile laboratory on a tour of duty in Florida. Other such labs are on the way. The Florida traveling lab visits the various ports and is able to save analysis time and also do more analyses than was the case when all lab work was sent to Atlanta.

* * *

The Environmental Protection Agency recently questioned the safety of raising food products on farms in Ohio adjacent to an industrial plant which emitted fumes containing beryllium residues. FDA tested the food raised on close-by farms and found no beryllium.

* * *

A fly in a bottle of Pepsi Cola started an inspection of a bottling plant. What the FDA calls extraneous matter was found in several filled bottles. The company voluntarily ceased operation, recalled all distributed products, destroyed 8,000 cases of soft drinks, cleaned everything, and repaired equipment before resuming operations. ◄

From THE JOURNAL 50 Years Ago

If excessive and continued hemorrhage is suspected, immediate operation is indicated. If it is not suspected, the patient should be covered with blankets and surrounded with hot water bottles, atropin should be given hypodermically and hot salt solution should be administered by rectum, subcutaneously or intravenously. After reaction, and we usually get it, an attempt is made to make a diagnosis. An ice bag should not be used. Truly, it allays pain, but it abates rigidity and masks other symptoms as would a dose of morphine.

The application of the ice bag to relieve pain and give the patient comfort has long been practiced in cases of suspected peritonitis. This is done routinely by a great number of men. By some until the diagnosis is established. . . . If cold is applied intermittently there will be a reaction whenever it is removed, and this reaction causes increased hyperemia. Hence, cold must be continued in action to prevent reaction. This fact would contraindicate its use in the old and feeble.

Because of the above mentioned reason we should be very cautious in the employment of the ice bag in inflammations. Far better is the employment of heat. Needless to say, the popular notion that heat and cold act alike is erroneous. For in order to obtain the effect of the ice bag, heat would of necessity be so intense as to be destructive of the superficial and even deeper tissues. Heat, employed as we all use it, is a distinct aid to nature in the process of fighting infection. Instead of inhibiting the defensive mechanisms of our bodies, we help them to become as quickly effective as possible. Heat increases the nutritive activity of cells, relaxes the lymph spaces and channels and tends to relieve the existing stasis, thereby increasing the vitality of the tissues and thus preventing gangrene. Heat further brings more blood to the part, and hence many leucocytes, and increases ameboid activity, thus inviting the migration of leucocytes which help fight the infection. Therefore, heat helps to localize instead of spreading a microbic process. . . . Jacob K. Berman, M.D., Indianapolis, "Abdominal Emergencies, Medical and Surgical," **JISMA**, August 1924.



TAX TIPS

by LAWRENCE A. JEGEN, III

Mr. Jegen is a professor of law at Indiana University Indianapalis Law Schaol, specializing in taxation, business assaciations and estate planning. Prafessor Jegen urges the reader ta consult the reader's lawyer before applying the data in this article to a particular fact situation.

This article is the second article in a series which concerns the estate planning possibilities which are available with private annuities. The first article of the series appeared last month and the reader should read (or re-read) that article prior to reading this one, because I intend to refer to the illustration of the private annuity which is presented therein.

Briefly, the example involved a sale of land by a father to his son, which land had a fair market value of $60,000, an adjusted basis to the father of $20,000, and for which the son was to pay the father $7,200 per year for the remainder of the father's life, which was estimated to be 10.1 years. The present value of the son's promise to pay the annuity (per the 6% annuity tables in the Treasury's Regulations) was $42,-749.

Thus, the father made a taxable gift of $17,251 ($60,000 minus $42,749) to the son.

Further, the father excluded, for income tax purposes, 27.5% of each $7,200 payment—namely, $1,980, as return of his adjusted basis. The 27.5% was determined by dividing $20,000 by $72,720 ($7,200 x 10.1).

Further, the father had to report, for income tax purposes, $22,749 ($42,749 - $20,000) of long-term capital gain over 10.1 years, namely, $2,252 per year.

In addition, the father had to report each year, for income tax purposes, ordinary income of $2,968 ($7,200 minus $1,980 and minus $2,252).

Finally, after 10.1 years, the father had to report each year, for income tax purposes, ordinary income of $5,220 ($7,200-$1,980)

Now for some additional observations.

Notice that the father was considered to have made a taxable gift, for gift tax purposes, because the fair market value of the land, at the date of the sale of the land to the son, exceeded the present value of the son's promise to pay the annuity. Thus, if the father had agreed to transfer to the son only the amount of land value which equaled the value of the annuity (so determined), then the father would have avoided a taxable gift. That is, in planning a private annuity, you might consider limiting the transfer of property so that the value of the property sold equals the value of the child's promise.

However, as a practical matter, the child may think (and the parent agree) that the value of the child's promise is higher than the arbitrary value which is established by the I.R.S., when it requires the use of the present-worth tables in the U.S. Treasury Regulations. In such a case, the child might require the parent to sell property which has a value that exceeds the present worth value. And, in such a case, the parent may lack the donative intent, which is a necessary element of a gift, for gift tax purposes. Thus, while a lawyer should always carefully document the basic facts which are involved in an annuity sale, even more care should be taken in order to document such facts where the value of the property sold is greater than the actuarially determined value of the purchaser's promise.

In general, a sale of property in return for a promise to pay an annuity is an excellent method to transfer property out of a parent's estate. However, it is most useful where the parent is required (due to parent's economic situation) to live on the annuity payments. That is, if the parent merely puts the annuity payments in a bank account, then the parent has probably not done much more estate planning than to trade one of his assets (e.g., land) for another (e.g., cash). Worse yet, the parent has probably subjected himself to an income tax (on a portion of the annuity payments, as seen above), which would not have been imposed, had the parent kept the property until death. If the property sold is income-producing property, then the parent is able to shift the income taxation (on the income from the property) from the parent to the purchasing-child. However, since the parent may also be taxed on the annuity payments, there is a double income tax—once on the income from the property (taxed to the child) and once on the payments to the parent (taxed to the parent). The latter tax only comes into being because of the sale.

However, this is not to say that the parent should not sell income-producing property. The child may need the income in order to make the annuity payments. Also, to state again, the income tax on the income from the property *is* shifted from the parent to the child.

A sale of property by an annuity arrangement is often desirable because the sale allows the parent to see the child utilize, work, or develop the property during the parent's life. However, the child might look upon the transfer as a burden, where the parent lives beyond the parent's estimated life expectancy, and the child continues to pay for property which the child would have received, ultimately, as an inheritance. In fact, the child might pay more for the property than the inherent fair market value of the property, and if the property is not income-producing property, the child might become distressed, at best, by the arrangement. In such cases, parents might be wise to encourage their children to come to dinner more frequently—which probably is not a bad idea anyway. ◄

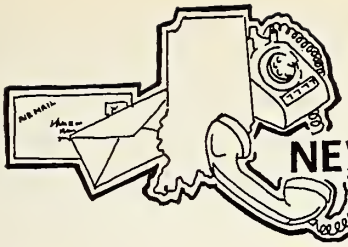
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New Pathology Diplomates Announced

The American Board of Pathology has announced that the following Indiana physicians became diplomates as a result of the Board examination in May 1974.

Luis N. Galup, M.D., South Bend, chemical pathology
John A. Griep, M.D., Indianapolis, blood banking
Yoichi Kino, M.D., Gary, anatomic pathology and clinical pathology
Edward Ming-che Lai, M.D., Terre Haute, anatomic pathology and clinical pathology
Tjien O. Oei, M.D., Indianapolis, radioisotopic pathology
Norvel D. Sisson, M.D., South Bend, forensic pathology
Douglas A. Triplett, M.D., Muncie, blood banking
Olin K. Wiland, M.D., Richmond, radioisotopic pathology

Dr. Snively Coauthors Book

Dr. W. D. Snively, Jr., Evansville, is a coauthor of the second edition of Nurses' Handbook of Fluid Balance with Norma Milligan Metheny.

Hospital Honors Veteran Staffers

Thirty-one doctors who have held staff membership at St. Joseph's Hospital, Fort Wayne, for more than 25 years were honored at the hospital's third annual Recognition Dinner recently.

Years of service ranged from 26 to 52 years for a combined total of 1,070 years.

Honored were: **Drs. Nathan L. Salon, William Clark, Sr., Harry W. Salon, Dr. Carroll O'Rourke,** Orville C. Briggs, **Harry Garton, Richard H. Miller, Charles J. Cooney, Joseph H. Baltes, Robert H. W. Brosius, Walter J. Rissing, Paul L. Stier, George G. Lenk, Lawrence W. Mueller,** Irvin Weintraub, **S. C. Michaelis, Herman G. Haffner** and James L. Wyatt III.

Also, **Drs. Arthur F. Hoffman, Richard N. Kent, Robert M. Lohman, John H. Nill, Robert J. Schmoll, Richard C. Stauffer, Floyd B. Walker, Roland B. Wilson, Chester Warfield, Emory D. Hamilton, Frederic L. Schoen, Louis A. Schneider** and John R. Weber.

Dr. Gerald Nolan spoke on behalf of the medical staff.

Wins "Golden Apple" Award

Dr. Ray Firestein, director of the Coronary Care Unit at St. Joseph's Hospital, South Bend, has been voted the 1973-74 "Golden Apple" Award by the hospital's interns and residents as the physician who has made an outstanding contribution to medical education.

Drs. Norman Holtzman, Stanley Houser, Dean Richards, Harry Stimson and Donald White were among those who were awarded engraved plaques in appreciation of their educational work with the interns and residents in the hospital's family practice clinic.

Free-Loan Epilepsy Film Available

"Now Let's See Epilepsy" is a half-hour color 16mm film about the origins, problems with and treatment of epilepsy. It is presented as a free-loan film as a public service of the National Epilepsy League. It is oriented for public viewing. Requests for use of the film should be addressed to Association-Sterling, 866 Third Ave., New York City 10022. Alternate show dates should be suggested.

Cologne Ophthalmologist to Lecture

The Lederle Distinguished Lecturer Series, sponsored jointly by Lederle Laboratories and Davis and Geck, will be host to a distinguished ophthalmologist, Professor Hellmut Neubauer of West Germany. This is the first of a new series of post-graduate exercises and is a continuation of the medical education program which Lederle originated 25 years ago with the Lederle Medical Symposium Program. Professor Neubauer, of the University of Cologne, will address audiences at medical schools and eye institutes.

Journal of Homosexuality Announced

The new *Journal of Homosexuality* will be the first professional journal devoted exclusively to empirical research on homosexuality and gender identity.

This new quarterly will provide research contributions from psychology, sociology, and anthropology that lead to a better understanding of lesbianism, male homosexuality, and gender identity. The journal will also attempt to provide practical aids for helping professionals who, in various settings, may encounter problems involving homosexuality.

To obtain a free descriptive brochure on the journal write directly to the Publisher: Harworth Press, 130 West 72nd Street, New York, N.Y. 10023.

Give Intensive Care Instruction

Drs. Gerald McInerney and Donald Weniger, Michigan City, conducted an eight-week in-service education course in intensive coronary care for nurses at Walters Hospital. The hospital recently opened its new intensive care unit.

Hospital Staff Officers Named

Dr. John Heubi has been elected president of the medical staff at Marion County General Hospital; Dr. James Wright, vice president; **Dr. John D. Miller,** secretary; and **Dr. Arvine G. Popplewell,** treasurer.

Also at General Hospital, **Dr. Ronald C. Hamaker** has been named to succeed **Dr. Lewis E. Morrison** as chairman of the Department of Otorhinolaryngology.

Dr. Norris Elected to Board

Dr. Max S. Norris, Indianapolis, has been elected to membership on the board of directors of Hook Drugs, Inc. He is the first medical doctor to serve on the board.

"Key Facts" Pamphlet Offered

A PMA booklet "Key Facts" has just appeared in a new edition and is available to physicians for distribution to patients and general waiting-room use. It is a fact book which discusses prescription pricing, the socioeconomic effect of drugs, the search for new drugs, quality control and drug

research, and other characteristics of the industry, not usually appreciated by the general public. It is an ideal medium for public information. Copies are available at cost—$8 per hundred from: Public Relations Division, Pharmaceutical Manufacturers Association, 1155 Fifteenth St., N.W., Washington, D.C. 20005.

Congressman Hudnut Introduces Health Professions Loan Bill

Congressman William H. Hudnut III has introduced a bill known as the Health Professions Student Income Contingent Loan Act. It would provide a fund for loans to students of schools of medicine, osteopathy, dentistry, pharmacy, podiatry, optometry and veterinary medicine, with repayment after graduation of principal and interest. Repayment would be correlated with the physician's earnings. The fund would be self-sustaining.

Dr. Spencer Charter Diplomate

Dr. Beaufort A. Spencer, Bloomington, was recently notified that he has been named a diplomate of the American Board of Allergy and Immunology, and is a charter member of the new Board.

Methadone Limitation Ruled Illegal

FDA's limitation on the distribution of methadone has been ruled illegal by a U.S. District Court. The judge said that "FDA does not have the authority to restrict a drug's distribution after the agency has approved it as safe and effective." The regulation in dispute stated that methadone could be shipped only to treatment-rehabilitation programs and hospital pharmacies approved by FDA.

Dr. Davis's Athletic Career Reviewed

SPORTS HOTLINE, a weekly all-sports tabloid published in Marion, recently included a review of the athletic career of the late Dr. Merrill Davis, including a picture of the 1908 Marion High School basketball team on which Dr. Davis starred. Dr. Davis' Indiana University records in football and basketball are recounted, as well as his activity in organizing the first state high school basketball tournament in 1911.

Recipients of Brotherhood Award

Dr. Frederick H. Evans, II, Indianapolis, and Mrs. Evans, were among those who received the 1974 Brotherhood Award conferred annually by the Indiana Region of the National Conference of Christians and Jews. Recipients are recognized for "unselfish efforts to make real in this community the ideal of the Brotherhood of Man under the Fatherhood of God."

Pierceton Honors Dr. J. B. Mishler

The Pierceton community recently honored **Dr. J. B. Mishler** as its outstanding citizen. The award was made by the Chamber of Commerce. Dr. Mishler opened his medical practice in Pierceton in 1956.

Roche Offers Medical Film Catalog

The Roche Film Library announces a catalog of medical films which are available for medical meetings. A copy of the catalog may be obtained on request from the Roche Film Library, c/o Association Sterling Films, 600 Grand Ave., Ridgefield, N.J. 07657.

New Sandoz Laboratories Dedicated

A new medical research facility, the Sandoz Laboratories for Atherosclerosis Research, is now in operation at Case Western Reserve University in Cleveland. Sandoz Pharmaceutical funded the construction and will provide continuing funds for the next four years for basic research in cardiovascular diseases.

Assist with Tuberculosis Workshop

Drs. F. B. Warrick, Anthony Dowell and Donald Pell, Richmond, contributed to a workshop for nurses, "Tuberculosis Today," sponsored recently by Indiana University East and the American Lung Association of Indiana, East Central Affiliate.

Joins Father in Practice

Dr. J. William Wright, III, who has just completed a residency in otorhinolaryngology at the Indiana University Medical Center, will enter practice with his father, **Dr. J. William Wright, Jr.,** with offices at 5506 E. 16th St., Indianapolis. His practice will be limited to diseases and surgery of the ear.

Discusses Medical Aspects of Rape

Dr. Nancy Oehler, Brazil, participated in a "Citizens Against Rape" workshop on the Indiana State University campus at Terre Haute. Her topic was "Medical Aspects of Rape."

Medical Assistants Program Approved

The training program for medical assistants which is conducted by Professional Careers Institute of 5310 E. 38th St., Indianapolis, has been approved by the American Medical Association.

New Public Affairs Pamphlet Offered

"My Parent Is an Alcoholic. What Can I Do?" titles Public Affairs Committee Pamphlet No. 506. It is written for the estimated 20 million children and teenagers who live with a parent or with both parents who are alcoholics. It is priced at 35 cents for a single copy and less for multiples. The address is 381 Park Ave. South, New York City 10016.

Two Hoosiers Among Winners Of Clinical Pharmacology Awards

The Pharmaceutical Manufacturers Association Foundation announces clinical pharmacology awards for 1974 in the total amount of $370,000. Included is an award to Dr. August M. Watanabe, Indiana University School of Medicine, for study of effects of specific drugs on myocardial metabolism. Also

Ronald L. Long, Indiana University, will have a grant to investigate hypothalamic monoamines as a part of the program of medical student fellowships.

Certified by Board of Pediatrics

Dr. Robert M. Malachowski, has been certified by the American Board of Pediatrics and will practice in Indianapolis.

Errata

The Journal regrets any embarrassment caused by errors which appeared in the Roster in the June issue, as follows:

The names of the following members were inadvertently omitted:

Ivan Mejia, M.D., P.O. Box 5224, Fort Wayne 46805 (ANES)
Josephine F. Murphy, M.D., 505 W. LaSalle Ave., South Bend 46601 (Retired)
Robert M. LaSalle, Jr., M.D., 1025 Manchester Ave., Wabash 46992 (GS)

The medical specialty of the following physicians was incorrectly listed; the correct specialty designation follows the physician's name and address below:

Rustica Delumpa, M.D., 802 La Porte Ave., Valparaiso 46383 (PD)
H. Wayne Mayhue, M.D., 207 Sparks Ave., Jeffersonville 47130 (OBG)
Willis W. Stogsdill, M.D., 3266 N. Meridian St., Indianapolis 46208 (ANES)
C. M. Whitlock, M.D., 302 E. Jackson St., Galveston 46932 (OM and PD)

The address which appeared in the Roster for the following members was incorrect; the address shown below is the correct one:

William R. Chattin, M.D., 5430 E. 21st St., Indianapolis 46218 (PD)
Vicente Delumpa, M.D., 802 LaPorte Ave., Valparaiso 46383 (U)
Hugh K. Thatcher, Jr., M.D., 1010 E. 86th St., Suite 24, Indianapolis 46240 (GP)

Names of the following members were misspelled; the correct spelling appears below:

Lamberto V. Abeleda, M.D., 103 W. Washington St., Shelbyville 46176 (IM)
Louis W. Conway, M.D., 2600 Greenbush St., Lafayette 47904

New Members

The Journal welcomes the following new members of the Indiana State Medical Association:

ALLEN COUNTY
Charles E. Hansell, M.D., 3217 Lake Ave., Fort Wayne 46805 (FP)

CASS COUNTY
John W. Durkin, M.D., 829 E. Market St., Logansport 46947 (OBG)

FAYETTE-FRANKLIN COUNTY
Edmundo S. Ulgado, M.D., 1936 Virginia Ave., Connersville 47331

MARION COUNTY
Rodney E. Corson, M.D., 5317 East 16th St., Indianapolis 46218 (GP)
John F. Csicsko, M.D., Indiana University Hospitals, Indianapolis 46202 (GS)
Richard D. Graber, M.D., Emergency Room, Methodist Hospital, Indianapolis 46202 (FP)
Michael S. King, M.D., 1318 N. Ritter Ave., Indianapolis 46218 (Ob-Gyn)
Robert J. Morgan, M.D., 1318 N. Ritter Ave., Indianapolis 46218 (Ob-Gyn)
Terry L. Nofziger, M.D., 3349 Georgetown Rd., Indianapolis 46224 (FP)
Ward Elias Poulos, M.D., 3500 Lafayette Road, Indianapolis 46222 (PD)
Joseph C. Randolph, M.D., 2900 Galahad Drive, Indianapolis 46208 (ORS)
Arthur J. Sumrall, M.D., 3231 N. Meridian St. #56, Indianapolis 46208 (ORS)
William Lee Hildebrand, M.D., Marion Co. General Hospital, Indianapolis 46202 (GP)
Harold G. Halbrook, M.D., 1815 N. Capitol Ave., Indianapolis 46202 (CDS)

OWEN-MONROE COUNTY
David Allen Byrne, M.D., 727 W. 1st St., Bloomington 47401 (D)
David L. Holtzclaw, M.D., 413 West 1st Street, Bloomington 47401 (PD)
Michael L. Johnson, M.D., 640 South Rogers St., Bloomington 47401 (P)

ST. JOSEPH
M. Samir Bawab, M.D., 919 E. Jefferson St., South Bend 46222
David L. Bechtold, M.D., 704 North Main St., South Bend 46601 (GS)

W. D. Gatch, M.D.

A resume of the life of W. D. Gatch is being compiled for historical purposes. Acquaintances and former associates of Dr. Gatch are invited to write to Malcolm Herring, M.D., 1000 Walnut St., Apt. 501, Philadelphia, Pa., 19107, to inform him of anecdotes and reminiscences suitable for recording.

What's New?

Cardio-Pulmonary Instruments offers two models of pulmonary function testing systems for hospitals and clinics. The small model can be fitted to existing spirometers of all types. The large model comes with built-in spirometer. Designated "Econo-Lab" because of their low cost, they sell at $5,318 and $7,995.

* * *

Bendix has developed a mobile respiratory support system for use in the home, hospital or clinic. The self-contained system supplies oxygen-enriched air from room air without requiring the use of oxygen cylinders, chemical or gas fillings. The Bendix Respiratory Support System provides flow rates and concentrations from two liters per minute at 90% oxygen concentration to 10 liters per minute at 45% concentration.

* * *

Accent Publications has a new publication: "Sexual Adjustment: A Guide for the Spinal Cord Injured." It was written because, in spite of the wealth of rehabilitative material for the paraplegic, sexual rehabilitation has been left out. Although written for the paraplegic, the book offers important information to individuals with other physical disabilities. Price $4.95.

* * *

Marshall Electronics announces an arterial blood sampling kit with several special convenience features. A prelabeled resealable ice/sample bag is packed separately. The kit is available with either 10cc or 5cc syringe with syringe cap, heparin, needles, alcohol preps and sample bag.

* * *



"Your picture may soon be in there."

Miles Laboratories Research Division offers free of charge to all scientists a unique and highly useful horizontal calendar. It consists of a single sheet, 34" x23", containing a single line for each of the 12 months, with a one-inch blank square under every date for notations. Each day of the week is in a separate color. Calendars for 1974 may be obtained by writing Stephen Pietsch, Research Division, Miles Laboratories, Elkhart, Ind. 46514.

* * *

Wyeth has a new oral contraceptive which is estrogen-free and consists of a small dose (.075 mg) of the synthetic progestogen, norgestrel. The name is OVRETTE. Clinical trials have included 1,950 women for an aggregate of 20,833 months. OVRETTE is a highly effective means of birth control, though minipills as a class are not quite as effective as estrogen-progestogen oral contraceptives.

* * *

McGraw-Hill has released a book for people who may join T-groups, encounter groups, or psychotherapy groups. "Inside Groups—A Practical Guide to Encounter Groups, and Group Therapy" by Thomas R. Verny, M.D. $7.95. It is written as a practical guide for those who wish to find out about the different approaches to groups and how to derive the most benefit from a group once they have joined.

* * *

"Teenage Contraceptive Services Handbook" is available at $2.50 from Planned Parenthood/World Population, 2340 Clay Street, 7th floor, San Francisco, California 94115. The handbook is specifically designed for the establishment of contraceptive and pregnancy counseling services for sexually active teenagers.

* * *

Speidel has a durable stainless steel bracelet called the Medilog identification bracelet which identifies the wearer's need for special medical attention in an emergency. It consists in part of latched carrier which contains a medical history form which conforms to AMA requirements. The official emergency medical identification insigne appears in red on the outside.

* * *

Boehringer Ingelheim announces a new aerosol bronchodilator, Alupent®, (metaproterenol sulfate). It is dispensed in a metered dose inhaler. Comparisons with the metaproterenol shows that its action is more pronounced and longer lasting than is that with isoproterenol.

* * *

Mead Johnson is introducing a new product ISOCAL™, a complete liquid diet specifically formulated to provide well-balanced nutrition when used as a sole source of nourishment. It is ideal for tube feeding. It is nearly isotonic with an osmolality of only 350 mOsm/kg water. This lessens the incidence of diarrhea, vomiting, cramps and nausea.

* * *

Deaths

James L. Bartle, M.D.

Dr. James L. Bartle, Indianapolis, died May 18 in St. Vincent Hospital. He was 71.

A 1927 graduate of the Indiana University School of Medicine, Dr. Bartle was a retired anesthesiologist at St. Vincent, having been on the hospital's medical staff 23 years before retiring in 1968. He had also practiced in the Lawrence area several years. He was an Army Veteran of World War II.

A member of the Marion County Medical Society and the American Medical Association, Dr. Bartle was also a member of the American Society of Anesthesiologists.

Jeryl R. Cates, M.D.

Dr. Jeryl R. Cates, 38, Indianapolis obstetrician, died at home on May 18, 1974.

A graduate of Hahnemann Medical College, Philadelphia, in 1964, Dr. Cates served his internship at St. Mary's Hospital, Evansville, and his residency in obstetrics and gynecology at Methodist Hospital, Indianapolis.

He was a member of the Marion County Medical Society and the American Medical Association.

Merrill S. Davis, M.D.

Dr. Merrill S. Davis, 84, Marion, died June 5 in University Hospital, Indianapolis.

After receiving the M.D. degree from Indiana University in 1914, Dr. Davis interned at St. Vincent Hospital in Indianapolis and, in 1915, entered the practice of medicine with his father at Marion. As a lieutenant in the U.S. Army Medical Corps in World War I, Dr. Davis attended Harvard University Medical School for special training in orthopedics and later was assigned to the Orthopedic Reconstruction Center, San Antonio. He served as Grant County coroner from 1941 to 1945.

A Fellow of the American College of Surgeons and of the International College of Surgeons, Dr. Davis was a member of the American Medical Association and a past president of the Grant County Medical Society and was also a past president of the 11th District Medical Society.

Dr. Davis was a founder and the first president of the I.U. Medical School Alumni Association and was also a founder and past president of the Indiana Bone and Joint Club.

Frederick W. Flora, M.D.

Dr. Frederick W. Flora, Frankfort, died in an airplane crash May 24. He was 48.

He graduated from the Indiana University School of Medicine in 1954, interned at the City Hospital of Akron, Ohio, and practiced at Clinton since then.

Dr. Flora was a member of the Clinton County Medical Society and of the American Medical Association. He served as county society president in 1959 and 1967 and served on the Commission on Interprofessional Relations from 1965 to 1968.

William C. Heilman, Sr., M.D.

Dr. William C. Heilman, Sr., 85, died in Henry County Memorial Hospital June 3.

Graduated from the Indiana University Medical School in 1916, Dr. Heilman began his practice in New Castle in 1919 after serving with the U. S. Army in England and France as a captain in the medical corps during World War I. He retired in 1969.

Dr. Heilman served as Henry County health officer during World War II and also as New Castle city health officer for a time. In 1960 he was made a member of the City Health Board.

A Senior Member of the Indiana State Medical Association, he became a member of the 50-Year Club in 1966; he also was a member of the American Medical Association and of the Henry County Medical Society.

Myron S. Harding, M.D.

Dr. Myron S. Harding, 77, Indianapolis, died June 9 in Community Hospital.

An ophthalmologist 48 years until his retirement in 1969, Dr. Harding was a graduate of the Indiana University School of Medicine in 1920. He was an Army veteran of World War I.

He became a Senior Member of the Indiana State Medical Association in 1966 and a member of the 50-year Club in 1971; he also was a member of the American Medical Association and the Marion County Medical Society. He was a diplomate of the American Board of Ophthalmology.

Wilbur J. Irish, M.D.

Dr. Wilbur J. Irish, 67, who practiced at East Chicago for 33 years and later served on the staff of Beatty Memorial Hospital until his retirement in 1970, died at Porter Memorial Hospital, Valparaiso, May 15.

Dr. Irish was a graduate of the Indiana University School of Medicine and was a former member of the Lake County Medical Society, the Indiana Academy of Family Physicians and the American Medical Association.

Fred B. Kurtz, M.D.

Dr. Fred B. Kurtz, 94, Indianapolis, died at home June 24.

A 1902 graduate of the old Illinois College of Physicians and Surgeons, Dr. Kurtz was a general practitioner at Indianapolis from 1904 until he retired in 1970.

He was a member of the Marion County Medical Society and the American Medical Association and was a Senior Member of the Indiana State Medical Association and a member of its 50-Year Club.

Charles W. Olcott, M.D.

Dr. Charles W. Olcott, Aurora, died June 14, 1974, in Christ Hospital, Cincinnati. Seventy-one years of age, he retired in 1973.

Dr. Olcott was a graduate of the University of Cincinnati Medical School in 1929 and was licensed to practice in Indiana in 1934. He also practiced at Cincinnati and was on the staff of the Dearborn County Hospital, Lawrenceburg, and Christ Hospital, Cincinnati.

A veteran of World War II, he saw service with the U. S. Navy, retiring with the rank of captain. For his service as Division Surgeon, landing on Iwo Jima on D-Day with the Fifth Marine Division, Dr. Olcott was awarded the Legion of Merit.

A Senior Member of the Indiana State Medical Association, Dr. Olcott was a member of the Dearborn-Ohio County Medical Society.

Warren H. Pike, Jr., M.D.

Dr. Warren H. Pike, Jr., Hobart, died in Hobart Mercy Hospital, June 21. He was 55.

He was graduated from the University of Maryland Medical School in 1945 and interned at Presbyterian Hospital in Chicago before entering the Army during World War II. He was a captain in the Medical Corps and served overseas.

On the staff of Gary and Hobart Mercy hospitals, Gary Methodist Hospital and St. Anthony Hospital in Crown Point, Dr. Pike served as deputy coroner for 16 years.

A member of the American Medical Association, he was also a member of the Lake County Medical Society.

Samuel Lewis Stern, M.D.

Dr. S. Lewis Stern, 72, who practiced in Hammond for 40 years before his retirement in 1971, and has since resided at Longboat, Fla., died in Carmel, Calif., May 26.

A former president of the medical staff of St. Margaret Hospital, Dr. Stern also served as chairman of the Hammond School City Medical Advisory Committee. He was a graduate of the University of Chicago Rush Medical School.

A member of the Lake County Medical Society, he was also a member of the American Medical Association and had been a Senior Member of the Indiana State Medical Association since 1971.

WANTED ! ! ! !

SHUTTERBUGS! "CRAFTY" WORKERS! "CANVAS-DABBERS"! FUN-SEEKERS!

WE invite YOU and/or your MATE to share your talents and interests in YOUR 1974 ISMA ART AND HOBBY SHOW, October 4, 5, 6, 7 and 8.

Address ALL applications and inquiries to:

Mrs. Harry Siderys, 9105 Kirkham Ct., Indianapolis 46260 or telephone 317-846-5030 before September 27, 1974.

Applicants will be further notified regarding final arrangements.

LOOKING FORWARD TO SEEING YOU IN OCTOBER!

ART AND HOBBY SHOW APPLICATION

Exhibitor _____ Phone No. _____

Address _____ City _____ Zone _____

EXHIBITS: Enter total No. items _____

MEDIUM	TITLE	SIZE

Special Note: I can ____ or cannot ____ help accompany the exhibits between the hours of ____ on _____ (date). You need not be an exhibitor to help with the exhibit.

Association News

BOARD OF TRUSTEES

Apr. 20, 1974

The Board of Trustees of the Indiana State Medical Association convened at the headquarters office building at 6:00 p.m., Saturday, April 20, with Vincent J. Santare, chairman, in the Chair.

Roll call showed the following:

Dist.	Trustee	
1	Bernard B. Rosenblatt	Present
2	Paul W. Holtzman	Present
3	Eli Goodman	Present
4	Howard C. Jackson	Present
5	Cleon M. Schauwecker	Present
6	Paul M. Inlow	Absent
7	John O. Butler	Present
7	Joseph F. Ferrara	Present
8	Richard G. Ingram	Present
9	William M. Sholty	Present
10	Vincent J. Santare	Present
11	James A. Harshman	Present
12	John S. Farquhar, Jr.	Present
13	G. Beach Gattman	Present

Dist.	Alternate	
1		
2	Betty Dukes	Absent
3	Thomas A. Neathamer	Present
4	Wm. F. Blaisdell	Present
5	Wm. G. Bannon	Absent
6	Glen Ward Lee	Present
7	Donald C. McCallum	Present
7	John G. Pantzer	Present
8	Jack L. Alexander	Absent
9	Max N. Hoffman	Present
10	Martin J. O'Neill	Present
11	Lloyd L. Hill	Absent
12	Walter D. Griest	Absent
13	Donald S. Chamberlain	Present

Officers and Executive Committee:

Joe Dukes	Absent
Gilbert M. Wilhelmus	Absent
Hugh K. Thatcher, Jr.	Present
Arvine G. Popplewell	Present
Frank B. Ramsey	Present
James H. Gosman	Present
John W. Beeler	Present
William R. Cast	Absent
Donald M. Kerr	Present
William R. Clark	Present

Guests Present:

Dr. Maurice Glock
Dr. Thomas C. Tyrrell
Dr. Peter R. Petrich
Dr. P. J. V. Corcoran
Lee Mortenson, AMA Field Representative

ISMA Staff:

Robert J. Amick	Present
Kenneth W. Bush	Present
Howard Grindstaff	Present
James A. Waggener	Present

The treasurer reported on the financial condition of the Association and the report was approved upon motion of Dr. Harshman seconded by several.

Dr. Holtzman made inquiry concerning the $40,000 which is being held in escrow for the student loan fund, pointing out that students are no longer applying for loans from the Association. The secretary reported that it was his impression that the $40,000 was set up as an irrevocable trust. Dr. Holtzman then suggested that the Secretary check this trust, as he did not feel that this $40,000 should be left in this fund, inasmuch as no loans are being made against it. Dr. Holtzman then raised the question as to who had the authority to determine the investment of Association funds. Doctor Thatcher then pointed out that no long-term investments had been made for the past five years, and the Executive Committee had the authority to make the decision with the advice of the Board of Trustees and the Indiana National Bank Trust Department.

The editor of the Journal, Dr. Ramsey, reported on the operation of the Journal and informed the Board there was a vacancy on the Editorial Board, and upon motion of Doctor Schauwecker seconded by several, Dr. Rodney Mannion of LaPorte was nominated to fill this vacancy. Upon motion of Dr. Gosman and seconded by several it was moved that the nominations be closed, and the Secretary cast the unanimous ballot for the election of Dr. Mannion.

The question then was asked of Dr. Ramsey why the "throw-aways" carried a lot of advertisements, and the legitimate publications seemed not to have much support. Dr. Ramsey pointed out that this was due to the fact that some of the throwaways circulate their distribution so more companies would advertise, and more specific circulation to various specialties who would use their advertisements. Dr. Ramsey went ahead to explain there was some thought to having one advertiser only, and it would cover the entire cost of publication of the Journal for that month, and requested some opinion from the Board on this idea. The chairman then called on the chairman of the Executive Committee to explain their attitude toward this proposal. Dr. Kerr reported that the Executive Committee felt this would be a bad move. Upon motion duly made and seconded, the Board voted to disapprove this idea.

REPORTS OF THE TRUSTEES

1st District, Dr. Rosenblatt reported that their Meeting would be held at the Rolling Hills Country Club at Evansville on May 9. Dr. Rosenblatt then moved the remission of dues for a doctor who is totally disabled and unable to practice due to a vehicle accident. The motion was duly seconded, put to a vote and carried.

2nd District, Dr. Holtzman reported that their meeting would be held June 13, 1974, at the Elks Country Club, Sullivan.

3rd District, Dr. Goodman announced their meeting would be held on September 14 and 15 at the Marriott Inn in Clarksville and extended an invitation to all the trustees.

4th District, Dr. Jackson reported their meeting would be held June 12 at the Seymour Country Club.

5th District, Dr. Schauwecker announced their meeting would be held at the Turkey Run State Park on May 22, and they would have as speaker Dr. George Crane, father of the Chairman of our Public Information Committee, Dr. David G. Crane of Bloomington.

6th District, Dr. Lee stated their meeting would be held May 9 at the Connersville Country Club, with golf in the morning and business in the afternoon, and Dr. David Crane would be the evening speaker. He also stated the district is offering prizes of weekend and overnight vacations at the Inn of the Four Winds at Lake Monroe. Doctor Lee moved that the dues of a Sixth District member be remitted for one year, because of illness. Seconded and carried.

7th District, Dr. Butler announced that their meeting would be held on June 5 at the Speedway Motel, Indianapolis.

8th District, Dr. Ingram announced their meeting would be held May 29 at the Anderson Country Club. Daytime will be golf, with business meeting late in the afternoon, and the dinner speaker will be The Honorable Otis R. Bowen, Governor of the State of Indiana.

9th District, Dr. Sholty stated their meeting would be held at Frankfort on June 13. There will be golf and the business session prior to dinner. Dr. Sholty also moved the remission of dues for a member who is closing his practice. Motion was duly seconded, put to vote and carried.

10th District, The chairman called on Dr. O'Neill to give the report and he stated their meeting would be held September 25 at the Valparaiso Country Club, golf in the morning.

11th District, Dr. Harshman reported that their district meeting would be held on September 18, 1974, in Logansport. They do plan to have a nationally recognized speaker, if they can find one they can afford.

12th District, Dr. Farquhar reported that their meeting would be held in Fort Wayne on September 12 at the Marriott Inn, with dinner at Win Schuler's Restaurant.

13th District, Dr. Gattman announced their meeting is scheduled for September 11 at the Elcona Country Club at Elkhart.

DR. SANTARE: I want to introduce a gentleman who is here this evening and he told me he is coming and going, Mr. Lee Mortenson, field representative

of the American Medical Association, who has been with us a number of times, and is now leaving us to take a position in Washington; I will ask him to say a few words.

MR. MORTENSON: Thank you, I just stopped by on the way to Washington, where I start my new employment on Monday. I am leaving the AMA and going with a managing consultants firm in the District of Columbia; The Resourceful Planning Group. I just wanted to take the opportunity to say goodbye and thank you for two very interesting years with the Association, and wish you the best of luck.

DR. FARQUHAR: I may be out of order, I think Lee has been a very good friend and honest man, and I have a message I would like to have him carry to Washington: that he should tell the AMA staff that their briefing to us in March was an insult to our intelligence. I felt it was the poorest staff briefing I ever heard, to stand in front of a group of grown men and state their position was to support PSRO as the law of the land. I am sure they recognized the House of Delegates was against PSRO, which should have been also their position. I would ask Lee to inform them that a lot of us were offended by their remarks.

The Chairman then called on others for any additional remarks.

DR. SHOLTY: I would just like to make the comment that this was my first trip to Washington, and I think Eli and I sort of tagged along, but I think this is one of the most important things this organization does, and I would encourage everybody in this organization to attend next year, because I think we made a lot of brownie points with the senators and congressmen. I think it is one of the most important functions of the ISMA.

DR. PETRICH: I have gone a couple of years as ex officio, and Dr. Farquhar's comments may be very appropriate and very accurate; however, there were several men in that meeting that were not from ISMA, and their comments were that they had been to three previous briefings and this was by far the best of all they had attended.

CHAIRMAN: Mr. Mortenson, do you want to rebut?

LEE MORTENSON: There is not much to rebut. I agree with you, the Washington staff appears to be schizophrenic, just as the House's stand seems to be (in some people's interpretation of the action in the Anaheim meeting). I do think they do a good job generally overall briefing for a lot of first-time Washington people. If you think they are schizophrenic now, I think you are going to see even more of this in the spring, because of the elections this fall. They are really going to make it difficult for the AMA House to stand up and take a stand and then get anything done on it. I have seconded Dr. Sholty's comments—get out to Washington a lot this year. Indiana is one of the more conservative states, and I feel you are going to keep most of your congressmen. Talk to them often and do anything you can to get them on your side. Medicine's House is going to need every Congressman it can get next year.

DR. KERR: I want to thank Dr. Sholty for what he said, because I agree with you. I think our Washington visitation is one of our most important functions. I think this particular year we had the best meeting we have had. We had a full attendance of all the senators and congressmen. Some just went by and kissed us and patted us on the head, but at least they were there.

Dr. Santare then discussed the proposed conduct of the balance of the meeting, particularly the discussion on PSRO, but that no action should be taken until the Sunday session when the president would return from a PSRO meeting in California. Finally, after a lengthy discussion, the motion was made not to have any discussion on Saturday evening. The motion was seconded, put to a vote and the vote was indecisive. It was then decided to have a roll-call vote, and, following discussion, a suggestion was made that this be a show-of-hand vote; the motion was then put before the Board, and the motion was carried for the matter to be discussed Saturday evening.

The Chairman then called upon Dr. Kerr, chairman of the Executive Committee, for his report.

DR. KERR stated the Executive Committee had discussed the condition of the reupholstery of the chairs in the Board Room, and some of the chairs in the other meeting rooms. They would have one lot of chairs, consisting of two side chairs, 18 conference chairs, 8 arm chairs and 4 other side chairs without arms, and the reupholstering for these chairs is a matter of $2,000. Look at your chairs and see if you feel that this is a necessary expense. They have been in use now for 12 years, and the Executive Committee would like to ask the Board's opinion whether they should spend this money at this time for reupholstery of them.

DR. THATCHER then moved that the Association reupholster the chairs, and the motion died for a lack of a second.

The motion was then made by Dr. Gosman to leave the decision up to the Executive Committee. This was seconded by Dr. Goodman, put to a vote and carried.

DR. KERR: The second item is that the Subcommittee on Rural Health of the Commission of Special Activities has the recommendation of the Student, Faculty and ISMA Retreat from two years ago that they offer a program of assessment of physician need and replacement in needy areas. There are funds available from HEW for this purpose, and we have submitted to us from the Subcommittee a budget for this program. The Association does not have the money, and HEW is interested in this program, and it was the thought of the Executive Committee that the recommendation to you is a do-pass action that we be at least allowed to investigate to the point of applying for funds to conduct this program and that we be allowed to proceed with this program.

Upon motion of Dr. Gosman seconded by Dr. Farquhar, it was moved that the Association apply for these funds. The motion was carried.

DR. KERR: The third item of information, which we thought you would be interested in, is that there is a first in the history of ISMA and that is from the will of the late Myrtle Lynn. The total estate was estimated around $10,000 and the ISMA will receive the balance of the estate after the burial and other expenses are paid from the estate. The fourth item is a letter which is addressed to Trustees Butler and Ferrara from the Marion County Medical Society. We would submit to you that we will give you this information, asking for no action again because it is related to PSRO business.

He then read a letter from the Marion County Society to the Board of Trustees suggesting that they should take positive action to apply for a grant to establish a PSRO Support Center.

DR. KERR: The next item is that we have called to your attention again that each member of the State Association is assessed $1.25 per year for the Medical Defense fund, and the Executive Committee has the responsibility of guarding these funds for using them wisely. We have received statements, in one particular case, from the doctor for his attorney fees in the amount of $1,131 for only two months for this one individual. We have previously informed you that there will have to be some revision in this whole structure. We bring this to you for your information and for your consideration as to any action from the House of Delegates in the time to come.

DR. HARSHMAN: I would hope that the Board would send a Resolution to the House of Delegates, and I would be in favor of stopping the Medical Defense Fund—period.

DR. KERR: This would require eliminating it from the Constitution.

DR. HARSHMAN: I don't belong to any other professional organization that offers this kind of service.

DR. GATTMAN: Another way to look at this is that it is a good service to our members. Why don't we make it something they can use, perhaps by increasing the dues to $5.00 for this pur-

pose, which should give us enough money to play with.

There followed a lengthy discussion, with the chairman sending this to the Medical-Legal Committee, of which Dr. Beeler is chairman, and suggested that they study this matter and come up with some suggestions for the Board at the next meeting.

Then, following further discussion, Dr. Gosman moved that the Board give the Executive Committee a vote of confidence for the way they have been handling the problem to this point. The motion was seconded, put to a vote and carried.

DR. KERR: As you know, we were to have a meeting at the Inn of the Four Winds at Lake Monroe, but because of conflicts it had to be changed. We have another meeting coming up in August and I have checked with people who run the place and the 23, 24, 25 of August is open. We can get 50 choice rooms if we want to meet there, and the weather should still be nice.

The motion duly made and seconded, the Board agreed to meet at the Inn of The Four Winds the 23, 24 and 25 of August, 1974.

The secretary then asked for clarification as to how the Trustees would be reimbursed for attending this meeting, pointing out that previously the Board Finance Committee had suggested the payment of mileage: flat fee of $50 for the Trustees and Alternate Trustees; and a flat fee of $25 to the AMA Delegates and Alternate Delegates, because they expect to be there for only one day.

DR. FARQUHAR: I move that for any meeting held in a resort location, the expenses for mileage and rooms both should be totally born by the individual trustees and alternates.

The motion was seconded by Dr. Ingram. A discussion then ensued; the motion was put to a vote and failed to carry.

The motion was then made that the Trustees and AMA delegates and alternates be paid mileage at the regular rate; and the Trustees and alternates get a flat fee of $50, and the AMA delegates and alternates receive a flat fee of $25. The motion was properly seconded and put to a vote and carried.

DR. KERR: The Executive Committee received a list of openings on the various councils and committees of the American Medical Association, which we present to you at this time, thinking that the Board and not the Executive Committee should make any recommendations.

DR. FARQUHAR: I would like to recommend Dr. Franklin Bryan for the nomination on the Council of Scientific Assembly. I would also like to place a recommendation that Dr. Eugene Senseny be nominated for the Council on Legislation.

The motion of Dr. Farquhar was duly seconded, put to a vote and carried.

Report of the Building Committee: Dr. Thatcher, Chairman of the Building Committee, explained the proposals of architects Merrill & Jones of Greenwood, and Lennox, Matthews, Simmons & Ford, the architects of the original building. Following discussion of the architects' proposals as far as fees are concerned, and upon motion properly made and seconded, the Board authorized the Building Committee to proceed with the plans for the new addition with the architectural firm of Lennox, Matthews, Simmons & Ford.

The secretary was then called upon to explain the program to be held on May 16 during the Leadership Conference of County Society Officers.

The chairman then read a letter from the Vigo County Medical Society inviting the State Medical Association to hold its annual Meeting in Terre Haute. The Chairman then appointed a committee of the Board, consisting of Dr. Rosenblatt, Dr. Harshman, Dr. Gosman, with Dr. Harshman, chairman, to study the invitation and report back to the Board.

DR. SANTARE: We have a letter from the Commission on Public Health concerning the widespread activity of many department stores and others offering to pierce ears. Mr. Waggener has referred this matter to the Medical Board of Registration and Examination, and I will read their reply that holds that piercing of ears is a medical procedure.

The motion was then made and duly accepted that the Board accept the opinion of the Board of Medical Registration and Examination.

Dr. Santare then moved on to the reports of the Board Committees.

Board Liaison Committee with Indiana University School of Medicine. No Report.

Board Liaison Committee with Blue Cross: Dr. Harshman. Dr. Harshman reported on the various subsidiary corporations being formed by the Blue Cross. Also they took action to subsidize B Agency Comprehensive Health Councils to the tune of about $80,000. The report was further discussed by several. The report was accepted.

Board Liaison Committee with Blue Shield: Dr. Holtzman. Dr. Holtzman gave a brief report on the experience that Blue Shield was having with the doctor's group and the prediction that further rate increases were in the future.

THE CHAIRMAN: We have had a question posed as to why the Blue Shield gave rebates to policyholders and proceeded to increase premium rates. Do you have any information on that?

Dr. Holtzman did not.

DR. HARSHMAN: It was explained to us one evening by Mr. Herod, and as near as I can remember, he said they did not wish to lower the premiums, that when you lower a premium it is difficult to raise back up again. So, they chose to give a rebate and keep the premium structure where it was.

The Board Committee for the Study and Implementation of Governmental Medical Programs: Dr. Gosman. No report.

Board Committee on Economic and Fiscal Matters: Dr. Goodman.

DR. GOODMAN: The only item I had to report on has been discussed, which dealt with the expenses of the August meeting.

Committee to Work with Health Careers, Dr. Butler. No report.

Board Liaison Committee with ISMA Auxiliary: Dr. Sholty.

DR. SHOLTY:

The Auxiliary is having their Annual Meeting in Brown County, which I plan to attend. I have no other report.

Board Liaison Committee with The Journal: Dr. Farquhar. No report.

CHAIRMAN: If there is no new business, I will announce that the next meeting of the Board to be held in Indianapolis on June 15 and 16. I will also remind you that June 16 is Father's day. If there are no objections, we will state that as the next meeting date.

DR. SANTARE: We will plan to meet tomorrow morning promptly at 9:00 a.m., and I will now declare the Board in recess at this time; but we shall now sit as a committee of the whole to discuss PSRO.

The Board then went into session as a committee of the whole, and discussed the pros and cons of PSRO, and had a presentation by Dr. Blaisdell of the activity is his area. In addition to PSRO, they discussed HMO, Pre-admission and Recertification, and many other points contained in PL 92-603.

The Board then recessed at 11:10 p.m., to meet again at 9:00 a.m. on Sunday, April 21.

BOARD OF TRUSTEES

The Board of Trustees of the Indiana State Medical Association convened in session at the headquarters building at 9:00 a.m., Sunday, April 21, 1974 with Dr. Vincent J. Santare, chairman, presiding.

Roll call showed the following:

Dist.	Trustee	
1	Bernard B. Rosenblatt	Present
2	Paul W. Holtzman	Present
3	Eli Goodman	Present
4	Howard C. Jackson	Present
5	Cleon M. Schauwecker	Present
6	Paul M. Inlow	Present
7	John O. Butler	Present

7	Joseph F. Ferrara	Absent
8	Richard G. Ingram	Present
9	William M. Sholty	Present
10	Vincent J. Santare	Present
11	James A. Harshman	Present
12	John S. Farquhar, Jr.	Present
13	G. Beach Gattman	Present

Dist.	Alternate	
1		
2	Betty J. Dukes	Absent
3	Thomas A. Neathamer	Present
4	Wm. F. Blaisdell	Present
5	Wm. G. Bannon	Present
6	Glen Ward Lee	Present
7	Donald C. McCallum	Present
7	John G. Pantzer	Present
8	Jack L. Alexander	Absent
9	Max N. Hoffman	Absent
10	Martin J. O'Neill	Present
11	Lloyd L. Hill	Absent
12	Walter D. Griest	Absent
13	Donald Chamberlain	Present

Officers and Executive Committee:

Joseph E. Dukes	Present
Gilbert M. Wilhelmus	Present
Hugh K. Thatcher, Jr.	Present
Arvine G. Popplewell	Absent
Frank B. Ramsey	Present
James H. Gosman	Present
John W. Beeler	Present
William R. Cast	Absent
Donald M. Kerr	Present
William R. Clark	Present

AMA Delegates and Alternates:

James A. Harshman	Present
Eugene F. Senseny	Present
Malcolm O. Scamahorn	Absent
Patrick J. V. Corcoran	Present
Lowell H. Steen	Absent
A. Alan Fischer	Absent
Ross L. Egger	Absent
Kenneth O. Neumann	Present
Thomas C. Tyrrell	Present
Peter R. Petrich	Present
Joseph E. Walther	Present
Sprague H. Gardiner	Present
Lall G. Montgomery	Absent
Myron H. Nourse	Absent

Guests:

David A. Clark	Present
Steven C. Beering	Present
Schuyler K. Geller	Present
David A. Crane	Absent
Kenneth J. Ahler	Present
Fred Smith, Jr.	Absent
Dwight W. Schuster	Absent
Donald E. Wood	Present
Hanus J. Grosz	Present
Glen McClure	Absent
William T. Paynter	Present
Robert Reed	Present

ISMA Staff:

Robert J. Amick	Present
Kenneth W. Bush	Present
James A. Waggener	Present
Howard Grindstaff	Present
Michael H. McDermott	Present
H. Edward Raffensperger	Present

CHAIRMAN: I will now call on Mr. Dave Clark, the executive director of the Indiana Pharmaceutical Association, for some remarks he wishes to make before the Board.

MR. CLARK: I would like to take this opportunity to afford you information concerning the Public Interest Research Groups being formed at universities, including Butler, Indiana State and Indiana University, to study, among other matters, varying charges for drugs at different pharmacies in a community and the variance of doctors' fees. This group is made up of the students, who are known as Nader's Raiders, Jr. He cited the study of drug charges in Bloomington, Indiana, pharmacies, the publicity that followed the survey and a medical survey published in the Washington, D.C., Star-News on doctors' fees, reporting a broad range of fees on first visits, and the practice of some physicians of "prescribing questionable drugs." This story came from the group's effort to compile a consumer's directory of doctors and a subsequent filing of a suit against Prince George's County Medical Society. The researchers, accusing the society and other professional groups of "massive opposition" to the doctor study, then filed in the U.S. District Court of Maryland a suit alleging free speech violation. The suit asks the court to require the county society to notify its members that providing information for the directory is legal. Following discussion, Mr. Clark merely said he was asking for understanding and cooperation between pharmacists and physicians to these types of surveys.

CHAIRMAN SANTARE: Our next guest was invited originally to give a presentation on our Commission on Medical Education and Licensure, but since that time he has achieved a new position, and on behalf of the state association, I want to congratulate the new dean of the Indiana University School of Medicine, Dean Steve Beering.

Dr. Beering reported on the activities of the Commission on Medical Education and introduced Mr. Edward Raffensperger, the new coordinator for the ISMA-CME Accreditation Program. He pointed out that the St. Joseph and Memorial Hospitals in South Bend, as well as the Deaconess Hospital in Evansville, St. Joseph's Memorial Hospital in Kokomo and Reid Memorial Hospital in Richmond, have all been visited by the team and are now waiting for their accreditation to be granted formally.

Dr. Beering then reported on the Regional Medical Program, stating that they had received $800,000 for specific projects for the Indiana RMP and had been given special status to utilize funds with more flexibility with less review. He is happy to announce that the RMP had approved an extension of funds for the operation of the Tel-Med program by the Indiana State Medical Association.

Dr. Beering continued by stating that Dr. George Lukemeyer has been elevated to the Executive Associate Dean, and has the responsibility of director of all I.U. hospitals.

He further stated Indiana University is now recognized as an international genetic center. Those of you who know Dr. Donald Merritt, Dr. Walter Nance and Joe Cristensen, I think, could recognize why we are singled out as an internationally important Genetic Center.

We were given a $700,000 grant, funded already for two years, with a guaranteed extension for another three years beyond, for a total of a million and a half for the Genetic Center activity. You might be also interested to know that we probably have $2,000,000 worth of cancer research going on at the medical school at this time.

CHAIRMAN: Are there any questions of Dr. Beering?

I have one question concerning the phasing out of the internship. In our particular area of the state, I notice that some of our hospitals are now requiring internship for admission to the hospital staff, it seems to me that this action is contrary to the type of thing we have been trying to do, and I would like to get a comment from you, both as chairman of our Commission on Medical Education and Licensure, and as dean of the Medical School.

DR. BEERING: That is a very serious problem, indeed, and I have been aware of that happening in one of your hospitals, because we had a letter asking us what is proper. In some states it is impossible to be licensed until you have passed one, two or three years of post M.D. training. North Carolina, for example, requires an internship and two years of training beyond, which may be either specialty training or military service. However, in this state and a variety of others, you can be granted a license to practice upon passing the Flex test immediately after receipt of the M.D., and this is indeed done by 99% of our graduates. While it is up to the individual hospital staff to find what it takes to join its ranks, in my judgment, it is slightly inappropriate for one hospital or more to sort of fly into the wind of what we have been doing in this field, which is grant an M.D., take a licensing test, grab a license (which is unlimited) to practice, and will certainly include hospital as well as office practice. So it is contrary, Mr. Chairman, to what we have been doing.

CHAIRMAN: I will now call on Dr. William Paynter, our State Health Commissioner.

DR. PAYNTER: I have three informational items to report to you. No. 1 is, that your commission asked for a

repeal of Regulation HT-6R, which dealt with skin testing for tuberculosis of entering school children. The wheels were put into motion, and I am happy to report to you that this was repealed by action of the Board on the 10th of this month, and I have sent a letter to Mr. Waggener in hopes that this information will be circulated widely. It does not repeal the law and still requires that the affidavit to the effect that a skin test has been done is available before the child enters school. I think it is a simple way to solve the problem. In essence, what it does, it permits the physician to use any method of skin testing that he so chooses.

The second item I would like to mention is in regard to the long-standing question about a Comprehensive Health Planning funding for an individual liaison person between the Indiana State Medical Association and the B Agencies of the state of Indiana. As far as we know, the funding of CHP will come to a halt on June 30, 1974, and I have been unable to find out what the prospects are for additional funding beyond that period of time. But if we are funded, I can assure you that we will move forward in this direction.

The third item is to inform you that the State Board of Health has received a grant of $703,000 for aid to tornado victims. The funds are being utilized to restore water and waste treatment facilities, to assist local health departments in carrying on extended service as needs have been created by this disaster, and for medical and surgical care of victims.

Thank you, Mr. Chairman, this is all I have to report.

CHAIRMAN: I would like to now call on Schuyler K. Geller, president of the Student American Medical Association, who is a sophomore at I.U. Medical School. He also has with him Miss Maria Ferraro, who is president-elect.

MR. GELLER: I want to thank the Association for making it possible for some of our delegates to be in attendance at the national meeting of the Student American Medical Association. We are allowed one delegate per 200 SAMA members, and we sent three delegates to the convention. We also sent four other alternate delegates. On the Reference Committees, Maria Ferraro was on the Administration and Organization Reference Committee, Mr. Tim Bark on Medical Education and I was Chairman of the Health Manpower Reference Committee. We were one of two schools that had three delegates on the Reference Committees.

Mr. Geller then reviewed some of the organizational activities of the Student American Medical Association's Annual Meeting.

CHAIRMAN: Dr. Eugene Senseny, floor leader of the AMA delegation, has requested that the delegates and the alternate delegates step out of the meeting for a little session of their own before reporting back to the Board.

CHAIRMAN: I will now call on Dr. Hanus J. Grosz, chairman of the Commission on Special Activities.

DR. GROSZ: I just want to report to you that the Commission is involved in making a study of the organizational structure of the various commissions and committees of the Association, and we would hope to have a report for you very shortly. Also, I have learned you have approved the requesting of a federal grant for funding the assessment program, which is a program of our subcommittee, for which I thank you very kindly. As soon as funding is received, we will be ready to go to work. This concludes my report, Mr. Chairman.

CHAIRMAN: I would now like to call on President-Elect Wilhelmus for his report.

DR. WILHELMUS: I believe our recent trip to Washington was very productive; for example, the meeting with Ray Madden, who is the second most powerful man in the Congress, next to Wilbur Mills, as Chairman of the House Rules Committee. We discussed with him the possibility of having hearings regarding the PSRO legislation, and nothing had been said about hearings up to that time in the Congress. Two weeks later the hearings were announced, and whether our visitation with the congressman had anything to do with this I do not know, but I believe it might have had some bearing upon the decision to hold hearings, because Representative Madden said he would discuss this with Representative Mills.

From my experience on these trips to Washington, I believe it would be very worthwhile for the officers of this Association to visit with the congressmen in Washington more than once a year.

My second point is that Blue Shield has a new medical man handling all our information that we have sent in, in regard to collections, and I would like to ask Doctor Santare, maybe at the next meeting, to invite this individual to our meeting, so we can meet him and maybe get more knowledgeable with him, so if we have problems we will know who to call.

My next item is: the Cost of Living Council, as we know, is going off the last of this month. In my opinion the politicians are very smart. I can just visualize medical health insurance; the first pitch they are going to have is "Look at the cost of health care; now, in the next 60 days its going to skyrocket. Whether it does or not, this is going to be their pitch. I would hope that the AMA and organized medicine will beat them to their pitch by making comparison of other professional groups' fee increases during this particular period.

This concludes my report, Mr. Chairman.

CHAIRMAN: Thank you, Dr. Wilhelmus; I will now call on our president, Dr. Dukes.

DR. DUKES: Since the last meeting of the Board, I have been to the AMPAC meeting in Washington, to an HEW meeting on PSRO, the Wisconsin Medical Society Meeting, the Chicago PSRO meeting, Bloomington PSRO session and the Eighth National Conference on Socioeconomics in San Diego. As a result of my various meetings on PSRO, I am not convinced that we need to get in a hurry to do anything about this subject.

Dr. Dukes then proceeded to explain some of the talks that had been given at the Conference on Socioeconomics, stating that it was too bad that every physician could not have heard some of these talks. He explained that HMO's were painted as being failures and it was felt that we had nothing to worry about as to this becoming a nationwide type of program.

Dr. Dukes also pointed out that he has long been an advocate of the universal claim form, and suggested that the Association put in a Resolution at the AMA level asking all states to adopt this as a uniform type claim form.

A discussion then ensued regarding several of the points made by Dr. Dukes during his presentation.

I would like now at this time to comment on the PSRO Support Center activity. One of the speakers at the meeting, a lawyer, discussed the possibility of the future data collection under the PSRO program. He stated that, in an Indian Reservation now, they have a process where a doctor, who is mobile throughout the Reservation, can push a button at any time and obtain from a centralized computer system, all the data on any one individual on that Reservation. He pointed out that this is one of the things that could happen under PSRO. He also stressed the fact that the information put into the computer should be just barely the necessities of information, and that one thing that we should remember is that while the patient may die, the computer record doesn't die, and we should find some method of making the computer records die also.

In view of this, I am thoroughly convinced that the Indiana State Medical Association should not do anything about a Support Center. I think we ought to stay away from it entirely, I think this organization should be a forceful buffer to produce sanity in all this conglomerate business as going on. I think we ought to be informed, I think we ought to be in touch with things going on, and I would be sympathetic to an organization outside the medical association itself, that might do a PSRO Center Activity. The thing that worries me

about the Support Center is that their main object is that they want you to educate the doctors, look for PSRO people and I am afraid that that will not let us get control of the data, and I think that is the utmost all-important of this whole situation — who controls the data. I have talked to Dr. Reed of Medi-tech at length about this and I would like for him to have an opportunity sometime today to discuss how he thinks that the data might be controlled.

I would recommend, then, that the Indiana State Medical Association not apply for a grant to establish a Support Center.

A lengthy discussion then ensued regarding the Darling case, requirement of continuing education as a basis for relicensure and recertification, and other points.

Following this discussion the chairman then called on Dr. Kenneth Ahler, a representative of the Commission on Public Information, to discuss some of the problems of the Commission in the absence of Dr. Crane.

DOCTOR AHLER: We are currently trying to assemble a list of professional speakers outside the field of medicine, and we hope to have one in each of the various regions of the state and preferably four that would be available to make talks on behalf of organized medicine.

At the meeting of the Commission this next week, we hope that we will have completed the list of available speakers that can be offered to you for appearances before your local organizations.

My real motive in being here today is to present to you another item from the Commission on Public Information, and this is a new pamphlet which we have written and wish to present today for your consideration. I will distribute copies of this for you to review and I have a few additional copies if you desire an additional copy. I am sure you are all aware that the State Medical Association about a year and a half ago published two pamphlets for public information concerning Medicaid and Medicare. It was the feeling of our Commission that perhaps insurance is one of the hottest issues right now facing medicine. And there was no particular pamphlet available which really explained to the people, particularly the state of Indiana, the doctors' point of view on insurance. How do you get it? What is it? What does it mean? So I've got insurance; is that the end of my problem? I think if you will take a couple of minutes and glance through this pamphlet, you will find that it is easy to read and can be read in about two or three minutes, which is the whole idea of the pamphlet, if we're going to the public for mass distribution.

A discussion then ensued regarding why the Commission on Medical Economics and Insurance had not seen a copy of this proposal.

Following discussion, Dr. Dukes moved that we send this information to the Commission on Medical Economics & Insurance for their review before it goes out, for any changes they would like to make. The question of cost was then raised, and Dr. Ahler said they had quotations from two different firms, one based on 100,000 copies @ 2¢ apiece, and the other printing firm based on 100,000 copies at a cost of $1,835.

Dr. Farquhar then moved that 100,000 copies be purchased for distribution.

A lengthy discussion then ensued and the chairman announced he was going to divide the question. First was to take a vote on the acceptance of the Commission's report. The motion was made, duly seconded and carried that the Commission report be accepted. The second part of the question, then, is the purchase of 100,000 copies of the pamphlet. A lengthy discussion ensued concerning this point, and Dr. Dukes then moved that the question be tabled until the June meeting, and that it be assigned to a Board committee of three to talk with the Medical Economics and Insurance Commission and report back. The motion was duly seconded, the motion was put to vote and carried.

CHAIRMAN: I will then appoint Drs. Wilhelmus, Inlow and Goodman; and Dr. Wilhelmus will Chair the Committee, to study this question and bring back a report at the June meeting of the Board.

CHAIRMAN: I will now call on Dr. Senseny, floor leader of the AMA delegation, for their report.

DR. SENSENY: As you all know, Dr. Donald Wood, an incumbent, will be running for the Board again, and I will get into that in a little more detail in a few moments. I would like to state at the outset that there are two of us in the delegation that will be on Reference Committees at the Chicago meeting. I have been assigned to the Reference Committee on Miscellaneous Business and Dr. Corcoran to the Reference Committee on Public Health.

At the Chicago meeting, which will run June 23 to 27, there will be seven openings on the AMA Board of Trustees, and there are nine candidates running. One of the major discussions at the meeting of the House is going to be the method of election of Trustees. One method will be running at large, one will be running on the slot basis, and the other is a type of thing such as you have with the presidential election, where there is a run off ballot by ballot, the low man drops out. I would like to suggest that the Board instruct the delegation to support the slotting mechanism at this point, because I think although Dr. Wood has a multitude of friends, this may be a little nitty-gritty this time for him to go back in, because I think there are a lot of people that are somewhat disenchanted with the Board, and he is our member from Indiana, so I would like to make this suggestion.

Following discussion, Dr. Thatcher moved that we instruct the delegation that the Board of Trustees moves that the election of Trustees of AMA may be by slots rather than at-large election. Motion was duly seconded; following discussion, Dr. Wilhelmus suggested that the delegates have authority to change this suggestion at their discretion later on. This suggestion was accepted as part of the motion of Dr. Thatcher and by the second.

CHAIRMAN: Is there other discussion? The Board is requesting, as I understand it now, for the AMA delegation to insist on the slotting if we can, but they are not committed to this, they can change it if they find that it is for our best benefits to change. Of course, this is dependent upon the approval of particular people enumerated by our president-elect; they were Dr. Wood, Dr. Senseny and Dr. Dukes, the chairman of the delegation. Any other discussion? The motion was then put to a vote and carried.

CHAIRMAN: I will now call on Dr. Wood, our Trustee.

DR. WOOD: The question of PSRO repeal is a mixed bag of worms. At the moment there is a great surge for repeal and cited, however, several states which were pro-repeal, but while pushing for repeal, were also seeking federal funds to establish PSROs. AMA is in a difficult position as this type of bilateral action occurs, he said. The AMA House of Delegates will have to make a clear-cut policy regarding this matter at the June meeting.

Motion was then made, seconded and carried to recess for lunch.

The Board reconvened following lunch and a roll call was taken and a quorum was announced as being present.

CHAIRMAN: We have some unfinished business, I would like to call on Dr. Petrich concerning the independent corporation to do peer review and quality control.

DR. PETRICH: I have been in consultation with the Executive Committee and with Mr. Waggener who has furnished me with considerable material. I am not for for-profit corporations in this particular area. I have not written out in detail the articles of incorporation or the bylaws, because I feel that first the principles involved should be approved by this Board before spending all that time and effort. I will give to you what I have given to the Executive Committee, which is the only portion of the plan I have written, which is the purpose for the corporation, which I would like to read to you.

The purpose of the corporation shall be to assist the physicians of Indiana to continue to improve medical care for the citizens of this state without compromising the traditional physician-patient relationship. This is to be accomplished by, but not limited to the following mechanisms: One, accumulating pertinent medical data in a confidential central computer bank, assisting local areas and establishing and coordinating peer-review type activities. Establishing an informational center for continuing medical education, to insure ready access and acceptability of poor content of material presented. Continuing to establish criteria for determining physician competence in maintaining quality medical care, and establishing an on-going and viable program to educate the public regarding medical care and their responsibilities pertaining to same.

The Bylaws will then continue with itemized articles of membership, officer structure, trustees, identification of officers and trustees, dues and so on, which is a sort of a routine kind of thing. Now, I have not coordinated it and I will coordinate it with your approval of the principles that I have just expounded to you as a purpose for our not-for-profit corporation for peer review activity, Mr. Chairman.

DR. FARQUHAR: I would move the approval of this report be accepted with appreciation and that it be implemented. Motion was seconded, put to a vote and carried.

The subject of financing the program and the possibility of using the grant for a PSRO Support Center as a means of partially financing the establishment for this independent corporation was discussed.

DR. DUKES: In reviewing the PSRO program manual, if you take a Support Center you must (1) educate all physicians in the area to serve the Support Center about PSRO Peer Review and Quality Assurance. (2) Identify the physician groups, areas served by Support Centers, which need assistance in meeting the requirement by the PSRO. (3) Assist physician groups in PSRO, serve the Support Center where there is no organization that has received conditional PSRO contracts in developing an organization and structure of a not-for-profit corporation consistent, and (listen to this), DHEW Rules, Regulations and Guidelines; and (4) which is to arrange initial consultations with the individual organization. You have all read all this. I don't know how this organization can accept and be a support center and be consistent with the House of Delegates' mandate to us. I think we can operate a PSRO; we have got to do it on our own and we can't do it with this kind of money.

CHAIRMAN: Dr. Dukes, will you take the Chair?

DR. SANTARE: I feel that this is a very serious question, and I think the State Medical Association ought to accept the offer being made to them by the government to keep its hands on this PSRO activity. I would, therefore, move that we apply for the grant for the Support Center for PSRO at the Indiana State Medical Association level. The motion was seconded.

A lengthy discussion then ensued concerning the advisability of the State Medical Association applying for a support center grant.

A lengthy discussion also ensued concerning the motion of Dr. Santare being out of order; finally it was moved to table the motion, and the move to table was also ruled out of order, and discussion then resumed.

A second motion was made then to table any action on this for the period of one meeting; it was seconded and a roll call vote was requested. The yes is a vote to table, and no is a vote not to table. The roll call is as follows:

Rosenblatt	Yes
Holtzman	No
Goodman	No
Jackson	No
Schauwecker	Yes
Inlow	No
Butler	No
Pantzer	No
Ingram	No
Sholty	No
Santare	No
Harshman	No
Farquhar	Yes
Gattman	No
Dukes	No
Wilhelmus	Yes
Thatcher	No

The motion to table lost by a vote of 13 to 4.

CHAIRMAN: We're now back to the original motion, which is to accept federal funds for this organization to be a statewide support center, in essence.

A roll-call vote was requested on this motion. A yes vote is to apply for a Support Center grant for the independent corporation, a no vote is opposed to applying for a grant for this outside organization.

Rosenblatt	Yes
Holtzman	No
Goodman	No
Jackson	No
Schauwecker	No
Inlow	No
Butler	Yes
Pantzer	Yes
Ingram	No
Sholty	Yes
Santare	Yes
Harshman	No
Farquhar	Yes
Gattman	Yes
Dukes	No
Wilhelmus	No
Thatcher	Yes

The motion lost by a vote of 9 to 8.

CHAIRMAN: We have a letter now from the Marion County Medical Society, asking that if the Board of Trustees did not vote to set up a support center, a special meeting of the House of Delegates shall be called. I would suggest to the Trustees from the Marion County Society that they refer to Article VIII of the Constitution, Section III, governing special meetings of the House. The Bylaws say that a special meeting of either the Association or the House of Delegates shall be called by the president upon receipt of a petition signed by 30 delegates, or 100 members. The signed petition shall contain the names of at least 10 delegates or 34 members from each of at least 3 Board Districts. Upon receipt by the president of such a petition, the president shall within 30 days thereafter issue a call for such special meeting at a time and place to be fixed by the president.

Therefore, under this provision of the Constitution, the Board does not have the right to call for a special meeting of the House.

CHAIRMAN: I will now call on Dr. Kerr to continue his report.

DR. KERR: As you know, the Commission on Medical Economics and Insurance has been investigating the Florida plan on physicians' liability or malpractice insurance. The Commission feels that, in order to find the true feeling of the physicians in this state concerning such a program, a survey would be necessary to determine what interest, if any, there is on the part of our membership in our setting up such a corporation.

Following discussion, a motion was made, duly seconded, put to a vote and carried, that the Commission be authorized to do such a survey.

CHAIRMAN: We had requested Dr. Fred Smith, president of IMPAC, to report to the Board at this meeting, but he was unable to attend and we are going to ask Mike McDermott to give his report.

MR. McDERMOTT: Dr. Smith asked me to apologize on his behalf for his inability to attend the meeting. He also wanted me to tell you that the IMPAC membership is running quite well thus far this year. As of March we had 2076 members, compared to 2206 at the end of 1973, so at this point we are some 175 or so behind last year's entire membership.

Indiana had a large delegation at the AMPAC Publicity Affairs Workshop. Attending were Mrs. Egnatz, Mrs. Gattman, Mrs. Himbaugh, Mrs. Ragan, Drs. Smith, Goodman, Taylor, Pantzer, Dukes and Wood.

A review was then given by Mr. McDermott of the reports they heard at the Workshop concerning the elections of 1974.

CHAIRMAN: Any new business?

DR. GOODMAN: I would like to propose a Resolution to be considered by this Board, to adopt a Resolution urging that the 55-mile speed limit on our highways which has saved many lives, as well as helping the fuel shortage, be maintained. The motion was seconded by Dr. Harshman.

DR. THATCHER: I would like to amend the motion by inserting a clause to urge strict enforcement.

The amendment was accepted. The motion was put to vote and carried. It was requested that copies of this final resolution be sent to the Governor and members of Congress from Indiana, and made public to the press in the form of a news release.

DR. GOODMAN: My second motion has to do with the statement made earlier today regarding PSRO. Dr. Wood pointed out that the House of Delegates of the AMA was going to have to resolve this issue and make a firm decision concerning their course. Therefore, I would like to move that our Association introduce to the House of Delegates of the AMA a resolution that would resolve and mandate the Board of Trustees of the AMA to actively work for and use its full skill and resources to bring about the repeal of PSRO. The motion was seconded, discussed, put to a vote and carried.

A letter asking for a physician to become a member of a group to promote the Kennedy-Griffiths Bill was reviewed and, upon motion made and duly seconded, it was decided that we would not become connected with this bill. The motion carried.

The question was then raised concerning the policy on the subject of physician's assistants. Following a lengthy discussion, a committee was named, consisting of Dr. Gattman, as Chairman, and Dr. Rosenblatt to prepare a resolution for submission to the Board, so the Board might consider it for introduction to the House of Delegates in October. Following discussion, Dr. Sholty moved that a resolution be prepared, and directing that the Resolution be against these people-physician's assistants. The motion was seconded.

The Chair then suggested that the resolution contain the thought that the Board wishes to place itself on record as being in opposition to the improper use of physician assistants in all categories. The suggestion was accepted by the person who made the motion, it was put to a vote and carried.

There being no further business, the Board then went into executive session.

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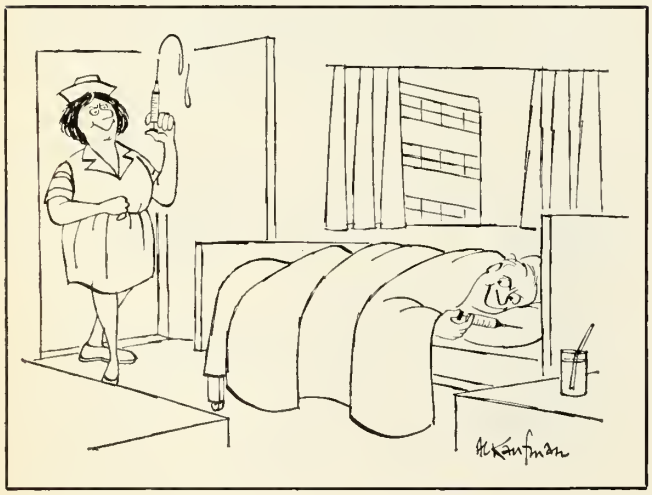
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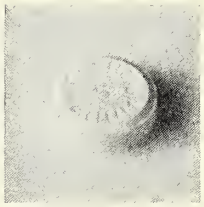
According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, although primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as the excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

There are other advantages in using Valium for the management of psychoneurotic anxiety with secondary depressive symptoms: the psychotherapeutic effect of Valium is pronounced and rapid. This means that improvement is usually apparent in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.

For further information on this subject, the following references are provided:

1. Henry BW, *et al: Dis Nerv Syst 30*:675-679, Oct 1969.
2. Hollister LE, *et al: Arch Gen Psychiatry 24*:273-278, Mar 1971.
3. Claghorn J: *Psychosomatics 11*:438-441, Sept-Oct 1970.



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in psychoneurotic anxiety states with associated depressive symptoms

surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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INDIANA STATE BOARD OF HEALTH

MONTHLY REPORT — July 1974

Disease	July 1974	June 1974	May 1974	July 1973	July 1972
Animal Bites	1108	1637	1019	1413	1345
Chickenpox	73	389	668	122	123
Conjunctivitis	187	251	216	304	205
Diphtheria	0	0	0	0	0
Dysentery, Unspecified	79	86	65	34	22
Gonorrhea	956	1532	910	686	866
Impetigo	188	157	122	259	182
Infectious Hepatitis	58	76	82	45	51
Infectious Mononucleosis	36	42	73	35	44
Influenza	2345	2214	2561	1063	688
Measles					
Rubeola	10	31	41	59	37
Rubella	26	65	54	21	44
Meningococcic Meningitis	1	0	1	0	0
Meningitis, Other	2	3	2	0	0
Mumps	46	142	137	83	50
Pertussis (Whooping Cough)	4	6	4	2	10
Pneumonia	270	509	392	297	213
Poliomyelitis	0	0	0	0	0
Streptococcal Infections	897	1583	1595	738	708
Syphilis					
Primary & Secondary	10	9	15	12	17
All Other Syphilis	76	144	103	65	93
Tinea Capitis	12	12	18	8	2
Tuberculosis (Active)	28	91	41	53	35

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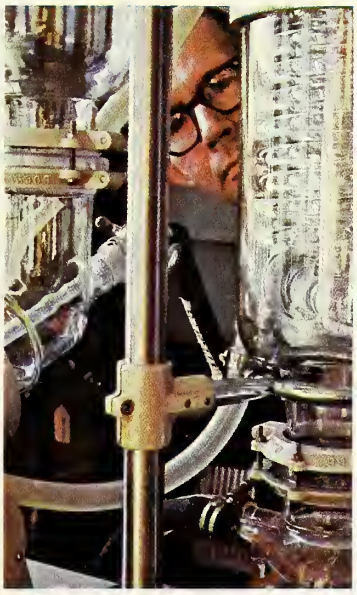
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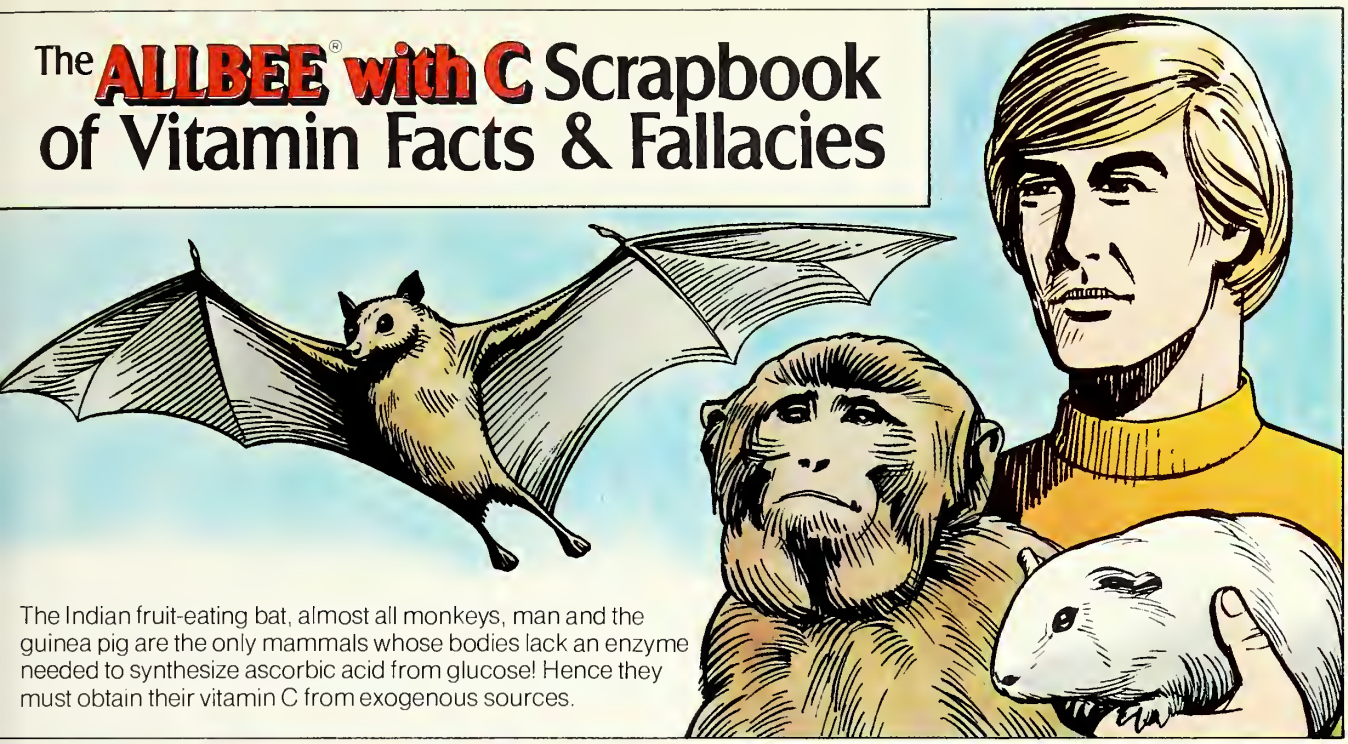
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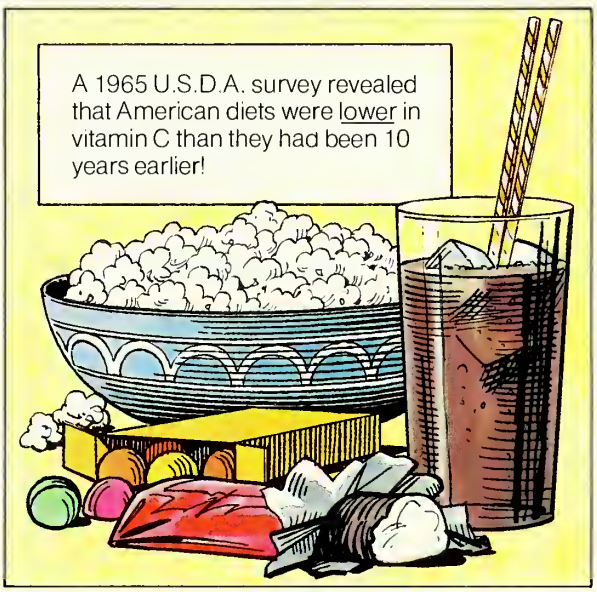
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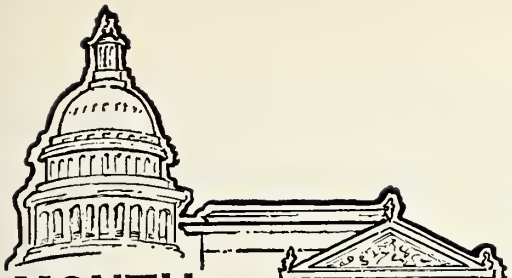
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MONTH IN WASHINGTON

This summary of what is happening in Washington is prepared by AMA's Capitol office and air-mailed to The Journal on the first of each month preceding month of issue.

Chances of passage this year of any national health insurance (NHI) proposal by either the Senate or the House seem to be dwindling away. The indefinite postponement of Senate Finance Committee hearings on NHI, plus the now ended lackluster once-a-week hearings by the House Ways and Means Committee that dragged out through the spring and early summer seems to indicate the Congress feels it has more pressing matters to deal with, or is baffled as to how to proceed with mandating health insurance for all.

Some veteran Capitol Hill observers believe the most important factor in congressional dawdling on the NHI issue is genuine bafflement—which has led to sharp controversy—on how such a program should be financed.

Most of the NHI proposals vary little in the scope of benefits. And there is no sharp disagreement that the program should be comprehensive in nature. And all but one or two of the proposals agree that the administration of the program should be derived from a combination of the federal and private sectors, using the existing private health insurance industry, controlled by federal guidelines and regulations.

The catch comes as to how the program should be financed. Should the program be financed by a Social Security payroll tax, or by mandated employer-employee financing, or by a tax credit system, such as proposed by the American Medical Association in its Medicredit plan?

It is in the area of financing that conservatives find the dangers of NHI. When a program is financed directly through federal revenues, it is an open invitation for government to use those dollars as a lever to manipulate the entire program—"an innappropriate intervention of the federal government into private affairs and responsibilities."

Each of the proposed methods for financing a NHI program has powerful allies, both in the Congress and in the private sector. And it would seem that this Mexican standoff is a major reason for this Congress' delay. Short of an unlikely compromise brought on by a complete about face by one of the major contending forces, it would appear that the 93rd Congress will not legislate a national health insurance program.

Another reason for congressional foot-dragging on NHI is that time is running out for the 93rd Congress and its "must" work is still piled high. For example, still to surface from the powerful House Ways and Means Committee is its promised tax reform measure, the long ago announced number one priority of the Committee.

And overshadowing all congressional priorities is the loom of time-consuming impeachment proceedings on the near horizon. "If the House votes to impeach President Nixon, forget national health insurance this year," says Abraham Ribicoff (D-Conn.), sponsor of a leading NHI bill.

House Subcommittee Strikes Down Controversial Plan

The House's Interstate and Foreign Commerce subcommittee on health has crushed by an 8 to 1 vote a public utility-like plan that would control physician fees and hospital charges, a provision regarded by many as the most threatening health measure on Capitol Hill.

The vote appeared to assure the doom of the public utility concept both in the full House Commerce Committee and the House. There remains the possibility of Senate approval, however.

The controversial provision is part of a comprehensive and complicated rewriting of the Comprehensive Health Planning and Regional Medical Programs of the federal government. The proposed strict rate controls exercised by the states are backed by Sen. Edward Kennedy (D-Mass.) and Rep. William Roy (D-Kans.), the latter a physician who cast the lone vote for the provision in the House subcommittee.

Opponents of the plan were subcommittee Chairman Paul Rogers (D-Fla.) and Democratic Reps. David Satterfield (Va.), Peter Kyros (Maine), L. Richardson Preyer (N.C.); and GOP Reps. Ancher Nelson (Minn.), Tim Lee Carter (Ky.), James Hastings (N.Y.), and H. John Heinz, III (Pa.). Absent but favoring the majority position were Reps. William Hudnut (Ind.) and James Symington (Mo.).

The vote was on a motion to strike from the bill language that would have authorized federal funding

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Alternates: Thomas C. Tyrrell, Hammond; Peter R. Petrich, Attica.

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2.	Jock L. Shanklin, Vincennes	J. S. Brown, Corlisle	
3.	Claude J. Meyer, Jeffersonville	J. L. Millan, Jeffersanville	Sept. 14-15, Clarksville
4.	A. A. Daftary, Batesville	Lanny Capeland, Osgood	Ripley County
5.	Poul Humphrey, Terre Haute	Fred Dierdorf, Terre Haute	
6.	Davis W. Ellis, Jr., Rushville	Clarence G. Clarkson, Richmond	
7.	Ray D. Miller, Mortinsville	M. O. Scamahorn, Pittsboro	
8.	Eugene M. Gillum, Portland	James S. Fitzpatrick, Portland	Portland
9.	Miltan W. Erdel, Frankfort	Horry T. Stout, Frankfort	Rensselaer
10.	Mario D. Mansueto, Munster	James R. Brown, Valporoiso	Sept. 25, Valporaiso
11.	Joseph S. Beon, Lagansport	Fred Poehler, La Fontaine	Sept. 18, Logansport
12.	Franklin A. Bryan, Fort Wayne	Karl R. Schlademan, Fort Wayne	Sept. 19, 1974, Fart Wayne
13.	Jack Hannah, Elkhart	David L. Spalding, Mishawaka	Sept. 11, 1974, Elkhart

for State Health Commission programs of regulating charges in the medical field with ultimate authority in the HEW Department.

Health providers have opposed the plan. Declaring that the legislation has "far reaching applications for the future delivery of health care services," Richard Palmer, M.D., Chairman of the American Medical Association's Board of Trustees, told the subcommittee earlier this year that under the disputed plan "the health sector, in effect, would be deemed to be one vast, monolithic public utility."

Dr. Palmer said, "We must caution against the imposition of a massive bureaucratic control of the health care system . . . the economic forces inherent in this proposal could defeat the intention of this Committee to foster the development of improvements in our health care delivery system."

The subcommittee adopted a requirement that the local planning agencies monitor individual institutional rates within the state and publicly comment on such rates.

Also included in the subcommittee draft are provisions to require states to have Certificate of Need legislation, or similar legislation relating to the construction of new facilities.

States would be required within three years to review and comment on the need for all facilities and services provided within the state.

Nation's Reliance On Foreign Medical Graduates Attacked

A slashing attack against the nation's reliance upon foreign medical graduates has been launched in Washington by the Association of American Medical Colleges (AAMC).

The present situation "undermines the process of quality medical education in this country and ultimately poses a threat to the quality of care delivered to the people," according to a report by an AAMC task force on FMGs headed by Kenneth Crispell, M.D., vice president for health affairs at the University of Virginia.

Endorsed by the AAMC executive council, the blunt assault on the immigration of FMGs called for application of the same graduate medical education qualifying examinations to all.

The report said:

"This country should not depend for its supply of physicians to any significant extent on the immigration of FMGs or on the training of its own citizens in foreign medical schools." If this results in a projected shortfall of supply, "appropriate measures including adequate funding must be taken to enlarge the student body (in domestic schools) accordingly."

The AAMC noted that FMGs are approaching 20% of all physicians here and one third of all current internship and residency training posts are filled by them. The foreign-trained physicians "perform at a lower level" in objective-type examinations, and "it is generally acknowledged, though not proven, that the medical care rendered by some FMGs is of poorer quality . . .," the report charged.

There is no evidence that FMGs either concentrate more on primary care or seek out shortage areas, according to the AAMC. Rather, in the aggregate, the FMGs follow about the same pattern in this regard as domestic graduates.

The report said special licensure provisions for FMGs in many state public institutions "suggests that much health care delivery in the public sector depends on physicians not fully qualified but willing to accept working conditions and income levels qualified physicians will not accept."

"The present system of accepting FMGs into the United States and incorporating them into our medical education and care system has created a category of second-class physicians. From an educational and ethical point of view, this is undesirable," the report said.

A decrease in FMGs would require new methods to ensure patient care services in many hospitals, the AAMC conceded, suggesting that other health care personnel be trained to perform some of these functions under the supervision of physicians.

The task force said it found no significant difference in the qualifications of FMGs who are American citizens who have gone abroad for their training and foreigners.

Non-Profit Hospital Employees to Come Under Taft-Hartley Act

Congress has passed and sent to the White House legislation bringing non-profit hospital employees under the Taft-Hartley Labor Act for the first time.

The legislation did not contain a 60-day cooling-off period following a strike call that had been sought by the American Hospital Association as a safeguard against sudden disruptions of service that could jeopardize care in hospitals.

Instead, the bill carried a 30-day cooling-off provision prior to a contract expiration that was supported by Labor and dismissed by hospital officials as essentially meaningless as far as public protection is concerned.

An AHA official said one result of the law would be to spur further the unionization of hospital workers and to generate new pressures for higher pay and fringe benefits. Inclusion under Taft-Hartley guarantees workers certain organizing, mediating and job rights that are not provided by all states.

For-profit hospital workers have been included under the National Labor Relations Act for several years.

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Cutback on Federal Aid to Medical Education Opposed

The American Medical Association has joined with the Association of American Medical Colleges in opposing the Administration's proposal to cut back on federal aid to medical education.

The Senate Health subcommittee was told by the AMA that "it seems particularly inadvisable to reduce support to institutions with national health insurance now being considered in the Congress."

"Moreover, any shift away from institutional support by requiring students or their families to provide the major portion of education costs through loans or service scholarships may prevent some able students from families with low incomes from contemplating or entering a health profession," the AMA said in a statement submitted to the subcommittee.

"This is not the time," the AMA statement said, "to make sudden shifts in federal policies and to create uncertainty and instability in educational or health care institutions."

At the same time, the AMA opposed a provision of a bill prepared by subcommittee Chairman Edward Kennedy (D-Mass.) that would require all medical school graduates to serve in shortage areas for two years. "These draft-like provisions would be unique to the health professions, would constitute a dangerous precedent, and would be contrary to fundamental concepts of the American educational system," said the statement.

Instead, the AMA fully backed provisions to increase support to the National Health Service Program for placing Public Health Service physicians and health personnel in shortage areas for two years.

In backing scholarships for students, the AMA urged that no strings of repayment or compulsory service be tied to them. They "should be limited to giving able students who could not otherwise enter medicine, or other health fields, the opportunity to do so."

In addition to assistance to students under the National Health Service Corps plan, the AMA backed continuing loan and scholarship assistance without requirement of mandatory service and with reasonable payback and loan forgiveness provisions.

AMA also supported provisions for expansion of programs in family medicine and primary care as well as authority to expand or construct ambulatory facilities "in which much of family practice and primary care must be learned."

Strongly opposed by the AMA was a recommendation in the Kennedy bill for relicensure of physicians. Said the AMA:

> Licensure per se cannot assure high quality of medical care or effectiveness of the practice of physicians. Relicensure has the same limitations. Under present circumstances the process of relicensure could severely disrupt the care of patients in many instances because physicians would have to prepare for examinations and be away from patient care while taking them. ◄

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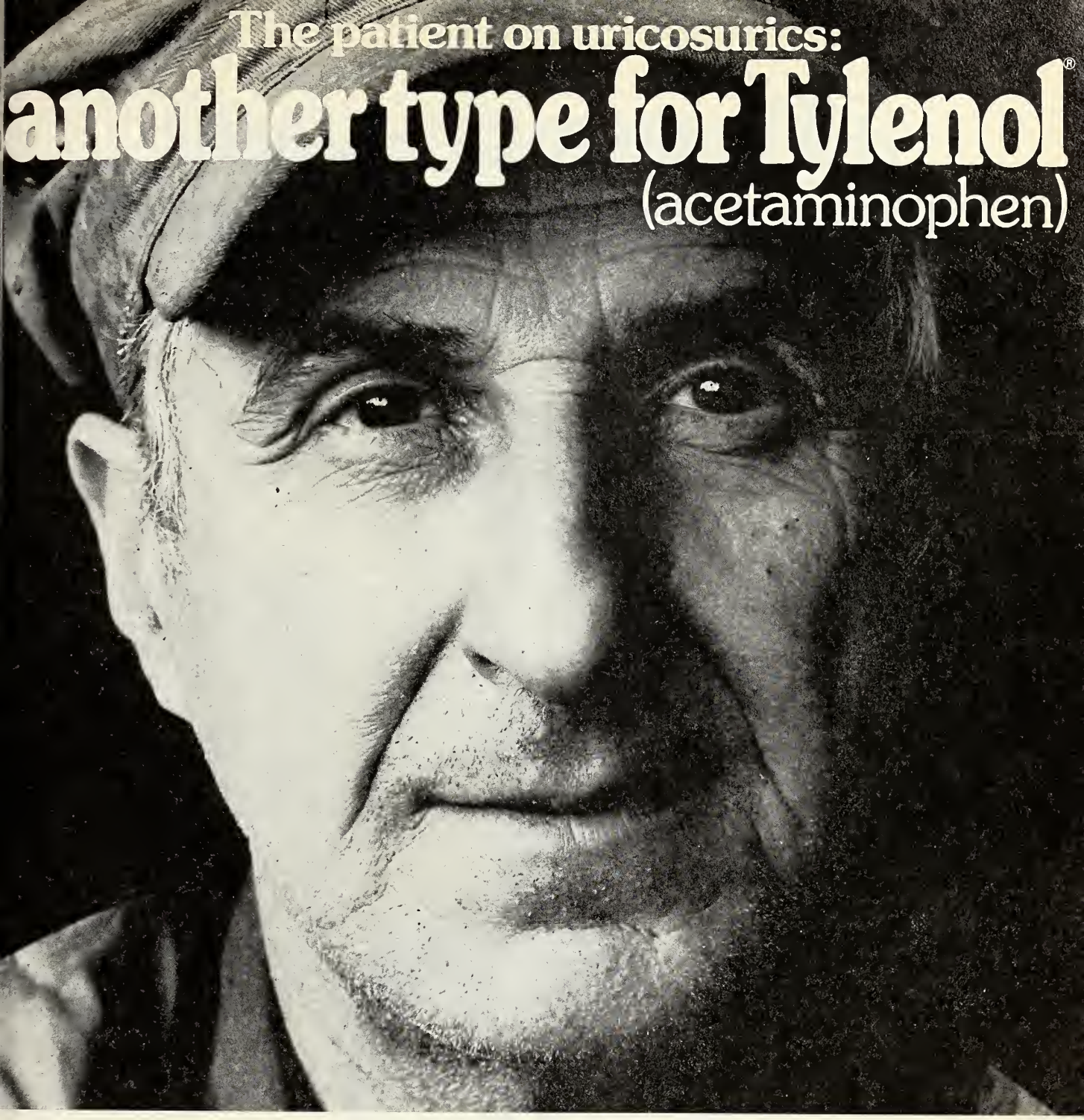
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References: 1. Martin, E.W., et al., ed.: Hazards of Medication, Philadelphia, J.B. Lippincott Co., 1971, p. 511. **2.** Seegmiller, J.E.: Med. Clin. North Amer. 45:1259-1272 (Sept.) 1961.

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Drops, 60 mg./0.6cc. (alcohol 7%).
Chewable Tablets, 120 mg.

Safer than aspirin, yet just as effective for relief of pain and fever

Tylenol®
(acetaminophen)

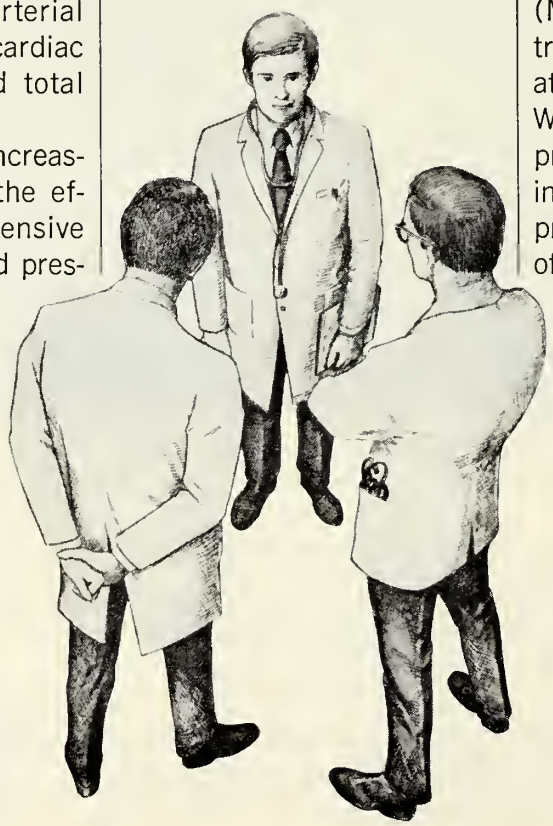
McNEIL McNeil Laboratories, Inc., Fort Washington, Pa. 19034

© McN 1973

The more physicians consider the hemodynamics of lowering blood pressure...

Most physicians now agree on the importance of reducing blood pressure in the hypertensive patient. But high blood pressure exists, of course, only as part of a complete clinical picture. The hemodynamic profile of well-established essential hypertension is characterized by elevated arterial blood pressure, normal cardiac output, and increased total peripheral resistance.

And so, physicians are increasingly concerned with the effects of an antihypertensive agent not only on blood pressure itself but also on the hemodynamic pattern—in short, with the total effect of the drug. *Does* it indeed help lower blood pressure effectively? *Is* peripheral resistance reduced? *Are* cardiac output and renal functions maintained? And, also, is there likely to be drug-induced postural hypotension serious enough to pose a threat to the patient's cerebrovascular status?

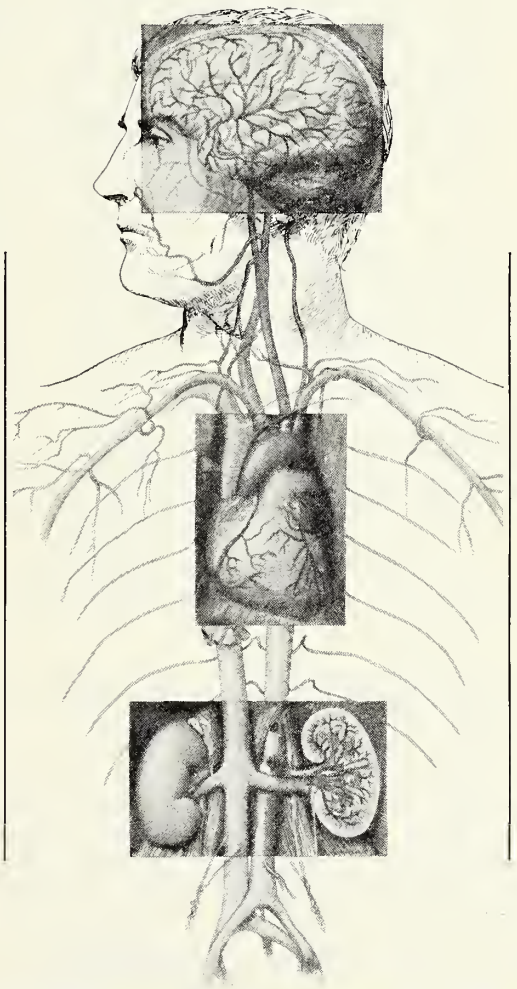


With this emphasis on overall drug performance has come a growing reliance on ALDOMET® (Methyldopa, MSD) in the treatment of sustained moderate hypertension.

With its unique hemodynamic profile, ALDOMET has drawn increasing attention and approval from physicians. First, of course, for its efficacy in

the more physicians rely on this unique antihypertensive

lowering blood pressure. But there are other considerations as well. Cardiac output is usually maintained with no cardiac acceleration; in some patients the heart rate is actually slowed. Peripheral resistance is apparently reduced. ALDOMET does not usually compromise existing renal function; it generally does not reduce renal blood flow, glomerular filtration rate, or filtration fraction. And ALDOMET usually does not cause symptomatic postural or exercise hypotension.



Contraindications include active hepatic disease and known sensitivity to the drug. Use with caution in patients with a history of liver disease or dysfunction. Not recommended in pheochromocytoma or pregnancy.

It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyldopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. For more details see the brief summary of prescribing information.

In most cases of sustained moderate hypertension

TABLETS, 250 mg and 500 mg

ALDOMET®

(METHYLDOPA | MSD)

smoothly lowers blood pressure

NEW now available in 500 mg TABLETS as well as the standard 250-mg tablets

For a brief summary of prescribing information, please see following page.

In most cases of sustained moderate hypertension

ALDOMET®
(METHYLDOPA MSD)

smoothly lowers blood pressure

Contraindications: Active hepatic disease, such as acute hepatitis and active cirrhosis. Known sensitivity. Not recommended in pheochromocytoma. Unsuitable in mild or labile hypertension responsive to mild sedation or thiazide therapy. Use cautiously in patients with history of previous liver disease or dysfunction.

Warnings: It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyldopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. Read this section carefully to understand these reactions.

With prolonged methyldopa therapy, 10% to 20% of patients develop a positive direct Coombs test, usually between six and twelve months of therapy. Lowest incidence is at daily dosage of 1 g or less. This on rare occasions may be associated with hemolytic anemia, which could lead to potentially fatal complications. One cannot predict which patients with a positive direct Coombs test may develop hemolytic anemia. Prior existence or development of a positive direct Coombs test is not in itself a contraindication to use of methyldopa. If a positive Coombs test develops during methyldopa therapy, determine whether hemolytic anemia exists and whether the positive Coombs test may be a problem. For example, in addition to a positive direct Coombs test there is less often a positive indirect Coombs test which may interfere with cross matching of blood.

At the start of methyldopa therapy, it is desirable to do a blood count (hematocrit, hemoglobin, or red cell count) for a baseline or to establish whether there is anemia. Periodic blood counts should be done during therapy to detect hemolytic anemia. It may be useful to do a direct Coombs test before therapy and at six and twelve months after the start of therapy. If Coombs-positive hemolytic anemia occurs, the cause may be methyldopa and the drug should be discontinued. Usually the anemia remits promptly. If not, corticosteroids may be given and other causes of anemia should be considered. If the hemolytic anemia is related to methyldopa, the drug should not be reinstituted. When methyldopa causes Coombs positivity alone or with hemolytic anemia, the red cell is usually coated with gamma globulin of the IgG (gamma G) class only. The positive Coombs test may not revert to normal until weeks to months after methyldopa is stopped.

Should the need for transfusion arise in a patient receiving methyldopa, both a direct and an indirect Coombs test should be performed on his blood. In the absence of hemolytic anemia, usually only the direct Coombs test will be positive. A positive direct Coombs test alone will not interfere with typing or cross matching. If the indirect Coombs test is also positive, problems may arise in the major cross match and the assistance of a hematologist or transfusion expert will be needed.

Fever has occurred within first three weeks of therapy, sometimes with eosinophilia or abnormalities in liver function tests, such as serum alkaline phosphatase, serum transaminases (SGOT, SGPT), bilirubin, cephalin cholesterol flocculation, prothrombin time, and bromsulphalein retention. Jaundice, with or without fever, may occur, with onset usually in the first two to three months of therapy. Rarely fatal hepatic necrosis has been reported. These hepatic changes may represent hypersensitivity reactions; periodic determination of hepatic function should be done particularly during the first six to twelve weeks of therapy or whenever an unexplained fever occurs. If fever, abnormalities in liver function tests, or jaundice appear, stop therapy with methyldopa. If caused by methyldopa, the temperature and abnormalities in liver function characteristically have reverted to normal when the drug was discontinued. Methyldopa should not be reinstituted in such patients.

Rarely, reversible reduction in leukocyte count with primary effect on granulocytes has been seen. Reversible thrombocytopenia has occurred rarely. When used with other antihypertensive drugs, potentiation of antihypertensive effect may occur.

Use in Pregnancy and Childbearing Age—Not recommended in pregnancy. In women of childbearing age, weigh potential benefits against possible fetal hazards.

Precautions: Methyldopa may interfere with measurement of: uric acid by the phosphotungstate method, creatinine by the alkaline picrate method, and SGOT by colorimetric methods. Since methyldopa causes fluorescence in urine samples at the same wavelengths as catecholamines, spuriously high levels of urinary catecholamines may be reported. This will interfere with the diagnosis of pheochromocytoma. Stop drug if involuntary choreoathetotic movements occur in patients with severe bilateral cerebrovascular disease. Patients may require reduced doses of anesthetics; hypotension occurring during anesthesia usually can be controlled with vasopressors. Hypertension has occurred after dialysis in patients on methyldopa because the drug is removed by this procedure.

Adverse Reactions: Sedation, usually transient, may be seen during initial therapy or when dosage is increased. Headache, asthenia, or weakness may be noted as early, transient symptoms. Symptoms associated with effective lowering of blood pressure are occasionally seen and include dizziness, lightheadedness, and symptoms of cerebrovascular insufficiency. Angina pectoris may be aggravated. Symptoms of orthostatic hypotension may occur; if symptoms occur, reduction of dosage is suggested. Bradycardia, nasal stuffiness, mild dryness of mouth, and gastrointestinal symptoms including distention, constipation, flatus, and diarrhea occur occasionally; these generally can be relieved by reducing dosage. Nausea and vomiting have been reported in only a few patients. Sore tongue or "black tongue," pancreatitis, and inflammation of salivary glands may occur.

Weight gain and edema occur infrequently and are relieved by administering a thiazide diuretic; if edema progresses or signs of pulmonary congestion appear, discontinue drug. A rise in BUN has been observed. Other rare reactions include breast enlargement, lactation, impotence, decreased libido, skin rash, mild arthralgia, myalgia, paresthesias, Bell's palsy, parkinsonism, psychic disturbances including nightmares, reversible mild psychoses or depression. Urine exposed to air after voiding may darken because of breakdown of methyldopa or its metabolites.

Note: Dosage should be limited initially to 500 mg daily when following previous antihypertensive agents other than thiazides. Maximal recommended daily dose is 3.0 g. Patients with impaired renal function may respond to smaller doses than patients with normal kidney function. Syncope in older patients has been related to increased sensitivity in those with advanced arteriosclerotic vascular disease; this may be avoided by lower doses. Tolerance occasionally seen either early or late, but more likely between second and third month after initiation of therapy; increased dosage or combined therapy with a thiazide frequently restores effective control.

How Supplied: Tablets, containing 250 mg methyldopa each, in single-unit packages of 100 and bottles of 100 and 1000; Tablets, containing 500 mg methyldopa each, in single-unit packages of 100 and bottles of 100.

For more detailed information, consult your MSD representative or see full prescribing information.
Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486

addendum

MSD
MERCK SHARP & DOHME

"Required Reading" For Your Hypertensive Patients



Because of the importance of patient motivation, Merck Sharp & Dohme offers "High Blood Pressure," a concise, pocket-sized booklet that defines the patient's own role in the management of hypertension. This booklet is available for you to give to your patients. It is designed to reinforce your explanation of hypertension and it emphasizes the importance of patient understanding in adhering to the regimen you prescribe.

Please ask your Merck Sharp & Dohme Professional Representative or write Professional Service Department, West Point, Pa. 19486 for a supply of this booklet.



"Lending" Your Home

Members of your church, club, lodge, or political party may want to hold a meeting in your home. If you say yes, what kind of legal responsibility are you taking on in case somebody gets hurt?

The answer usually depends on whether those who come are classified as social visitors or business visitors. Most courts say you owe only a moderate degree of care toward social visitors, but a high degree of care toward business visitors.

Which classification is the correct one for people who gather in a private home? They are not ordinary social guests, yet they have not come for business reasons either.

As a rule courts have decided that the social category, even if not exactly right, at least fits better than the business category. The practical effect is to reduce the home owner's responsibility for accidents.

Consider a typical case:

A woman opened her home for a meeting of college alumnae. During the evening, one of the visitors skidded on a loose throw rug and injured her shoulder. As a result, the hostess soon found herself facing a suit for damages.

But the court held her not liable. The court said the victim, just like an ordinary social visitor, had to take the premises as she found them.

On the other hand, the home owners's risk goes up when there is a business element in the day's arrangements. In another case, a woman allowed the local garden club to send sightseers to her home as part of a tour. But each person who signed up had to pay the club a fee.

This fact made all the difference later on, when an injured sightseer sought damages from the hostess. The court said payment of the fee gave the visitor the same special rights as a cash customer in a place of business.

A public service feature of the American Bar Association and the Indiana State Bar Association. Written by Will Bernard.

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INDIANA'S ONLY PRESTIGE ANTIQUES SHOW

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INDIANAPOLIS

Exposition Hall, State Fairgrounds, 1500 E. 38th St. (US 36 - SR 67)

11 A.M. - 10:30 P.M. ADM. $1.75 for 4 days
Sunday 11 A.M. to 6 P.M. Restaurant Acres of free parking

OCTOBER 31, NOVEMBER 1, 2, 3

Here under one roof is displayed the largest quantity of QUALITY antiques ANYWHERE! The greatest rarities in all categories; every price range.

Finest Early American, Georgian, Victorian and English silver. Signed American pewter. Paintings, prints. Oriental rugs. Priceless art and cut glass; pottery.

Early flint and Victorian pattern glass. Lacy Sandwich salts, cup plates and candlesticks. Flint pattern glass. Early flasks. Whole booth of rare dolls. Whole booth of early lighting devices and hearth accessories.

China export porcelain, Derby, Worcester, Leeds, Liverpool jugs, Meissen, lustreware, Gaudy Dutch. Tea caddies, samplers, inkwells, quilts, coverlets, hooked rugs. Old books, fine bindings, coins, paper Americana.

144 exhibitors. 62 dealers in fine early furniture c-1740 to 1840, American and English formal, informal and primitive; French and Oriental. Russian enamels. Icons. KPM porcelain, Tiffany, coins. Antiques for men.

All of the fine early things missing in most antiques shows today.
No flea market or Mall show exhibitors participate.

EMPHASIS ON AMERICANA

BUY WITH CONFIDENCE MONEY-BACK GUARANTEE QUALITY CONTROLLED

AN EDUCATION IN REAL ANTIQUES

NO OTHER INDIANAPOLIS SHOW COMPARES IN ANY WAY. CONSIDERED BY MANY TO BE THE FINEST ANTIQUES SHOW IN THE U.S.A. DON'T MISS IT! YOU DON'T HAVE TO BE A COLLECTOR TO ENJOY IT.

Jean Crutcher, Manager, R. 1, 7370 Old National Trail, E., New Carlisle, Ohio 45344

Tel-Med

Medical Advice by Phone

Do you have a pain in the neck?

If you do and its recurrence concerns you, but perhaps not yet seriously enough to visit a doctor, there is a way for you to find out whether that pain signifies medical attention—free and in complete privacy.

The Indiana State Medical Association has announced that its unique telephone health information service now has been extended to all citizens of the state.

Called Tel-Med, this unique program provides professional messages on neck pains, along with 210 other health and medical subjects, by simply dialing a toll-free number at Indianapolis.

The number is 800-382-5681.

Here's how it works:

The ISMA has prepared taped messages of three to five minutes in length on 211 medical subjects, all approved by the ISMA as medically correct.

Persons wishing to listen to a tape simply dial the number listed above and, when the operator answers, ask for their selection by number or title.

Copies of the tape list may be obtained by asking your physician or by sending a postcard request to the Indiana State Medical Association, 3935 North Meridian street, Indianapolis, Ind. 46208.

When the tape number is requested by the caller, the operator plays the tape which discusses the specific illness and steps that can be taken to recognize or prevent it. If one wishes to hear the tape again, repeat the call and request it played again.

Calls can be made in the privacy of the home and the identity of the caller remains unidentified.

The Tel-Med service was begun by the ISMA as a pilot program in the Indianapolis area over a year ago. It proved popular with the public there (80,000 calls in eight months) and it now has been extended throughout the state with support from the Indiana Regional Medical Program and Eli Lilly and Company.

The medical subjects covered by the 211 tapes are most comprehensive and only can be appreciated by obtaining one of the pamphlets listing them. However, to give you an idea of their scope, here are some selected titles:

Thumb sucking (and 29 other subjects on children), teen years—the age of rebellion, I'm just tired, doctor (for women), birth control, what causes pregnancy, fears of the after-40 man, venereal disease, narcotics, cigarettes and heart disease, what not to do for toothaches, epileptic convulsions, home care for the bedridden patient, the lady living alone, nine ways to cut your medical costs, breast cancer, chronic cough, acne, hemorrhoids, ulcers, understanding headaches, and arthritis and quackery.

The service is available from 10 a.m. to 8 p.m. Monday through Friday and from 10 a.m. to 6 p.m. Saturday; closed on Sunday.

This is an excellent public service and the ISMA is to be heartily congratulated for extending throughout the state. Not only does it enhance the busy doctor's ability to provide sound information to his patients, but it gives those patients the opportunity of determining on their own if their health symptoms require medical help.

The result of the service, if it is used, should be better health for all. Get a list of the tape library subjects soon. — *The Rochester Sentinel,* June 4, 1974.



McClain Car Leasing, Inc.

1745 Brown St., Anderson, Ind.

Phone 317/642-0261

Specializing in Professional Car Leasing

ALL MAKES AND MODELS AVAILABLE

We are proud to offer a Leasing Plan approved by ISMA

The Audi offers you one luxury most luxury cars can't afford.

Most luxury cars sacrifice gas economy in order to provide you with luxury.

The Audi 100LS doesn't.

You get the creature comforts of a luxury sedan.

Plus a very economical 24 miles to the gallon.

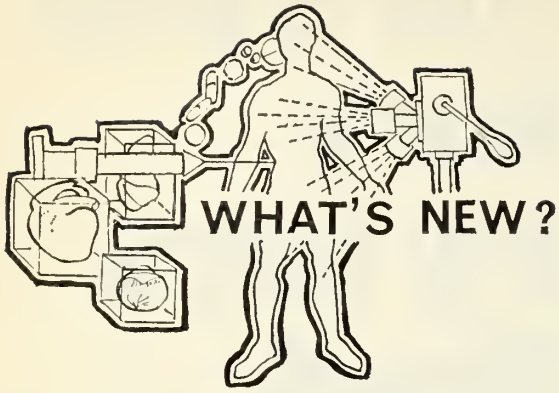
When you think about it, maybe the Audi is one luxury you can't afford not to own.

The 1974 Audi 100LS



OVERSEAS DELIVERY AVAILABLE

D-Patrick Imports, Inc.—Evansville
Kline Porsche Audi, Inc.—Indianapolis
Bircher Volkswagen, Inc.—Madison
Putnam Imports—Elkhart
Walt Coyle Volkswagen, Inc.—Marion
Shanks Motor Company—Terre Haute
Fort Wayne Porsche Audi—Fort Wayne
Jim Hamilton Volkswagen, Inc.—Columbus
Burgin Motors, Inc.—Logansport
Sadler Motors, Inc.—Vincennes
Porsche Audi Southlake, Inc.—Gary



Peterson Baby Products announces a new child auto seat which surpasses the current Federal Safety Standards. Called the "Safety Shell," the device is adaptable for toddlers in the riding forward position and for infants in the riding backward position. It has passed dynamic testing at the Automotive Safety Center of a leading university.

* * *

Bio/Data Corporation announces a Coagulation Profiler, the CP-7, which is an integrated semi-automatic system to perform routine analysis of blood plasma for changes or defects in the coagulation mechanism. It detects abnormal factor activity levels with every Prothrombin Time or Partial Thromboplastin Time Test.

* * *

POISINDEX is a comprehensive poison information system issued quarterly by the Rocky Mountain Poison Center at Denver General Hospital. It contains computer-generated data on more than 50,000 compounds with an average access time of less than 25 seconds. Each product is indexed alphabetically, numerically and by all known names, including manufacturers' names, brand and trade names, generic names and slang terms. Specific treatments are fully presented.

* * *

HOSPITAL & MEDICAL PLANNING, INC.
702 Abbott Road
East Lansing, Michigan
48823
517 332-1333

ATTENTION

General Practitioners — Surgeons
Internists — Pediatricians

We are searching for two Physicians to join an Emergency Group serving a 500-bed hospital located in a medium-sized city in Northeast Ohio. Group is headed by Board Internist. Congenial atmosphere. Prior experience as Emergency Room Physician not required. Change your life-style to a more normal and regular schedule with considerably more worry-free time off for yourself and family. Starting annual level is $50K with increases in succeeding years—plus other benefits of corporate group. Interested physicians may call or send their curriculum vitae in confidence and with no financial obligation to Arthur A. Lepinot.

Posey has a new decubitus pad designed to turn, hold and pull patients while it protects against decubitus sores. The pad is made of 72 ounces of Kodel per linear yard, which allows a higher pile and greater density. Four cloth straps, one at each corner, are useful in turning, moving and securing the patient.

* * *

Pfizer has a new rapid screening test for serum hepatitis. One drop of blood obtained by finger stick mixed on a slide with one drop of Latex Reagent will give a diagnostic answer in five minutes.

* * *

Gould Instrument Systems announces a new "Lifeguard" 1500 Series portable, battery operated defibrillator with built-in cardioscope, synchronizer, test circuit and battery charge indicator. It weighs 25 pounds and is easily carried. All high voltage circuits are isolated and the controls and tough plastic case are non-conductive.

* * *

Miles Laboratories Research Division has eight isolated lectins for sale. Researchers who require such substances may obtain them in pure form and avoid time-consuming preparation. Included are Concavilin A, Fucose Binding Protein, Wheat Germ Agglutinin and other sugar-specific proteins.

* * *

A new, miniature, battery-powered cardiac monitor with a built-in arrest alarm is a new addition to hospital and intensive care equipment from Isolette. It is completely portable and may be used in emergency rooms, for transport service, and in recovery rooms and x-ray departments. May be used on adults, children or newborns.

* * *

Ortho Pharmaceutical has a new fungicide, specific for vulvo-vaginal Candidiasis. MONISTAT™ Cream is well tolerated and is highly effective in pregnant and non-pregnant patients.

* * *

The Patient Care Division of Johnson & Johnson has a film available on a loan basis for medical meetings. It deals with a new method of treating tibial fractures, which permits early weight bearing and at the same time affords unrestricted motion of all joints of the injured limb. It is in the film library of the American Academy of Orthopaedic Surgeons or may be obtained from any representative of Johnson & Johnson Patient Care Division.

* * *

News of what is new in the medical supply industry is composed of obstracts from news releases by manufacturers—of phormaceuticals, clinical loboratory supplies, instruments ond surgicol applionces—and book publishers. Each item is published os news and does not necessorily constitute an endorsement of a product or recommendation for its use by THE JOURNAL or by the Indiana State Medical Associotion.

It occurred on June 6, 1849—

3 o'clock P. M.

Convention met pursuant to adjournment. The President in the chair. The committee appointed to prepare business for the convention, reported:

First. That they deem it expedient that the Convention take proper steps to organize a *State Medical Society* in Indiana; and that a committee be appointed to report a Constitution and By-laws for that purpose.

Second. That a committee be appointed to consider the expediency of establishing a Medical Journal, to be the proper organ of the profession in this State.

Third. That the Convention recommend in some suitable way to members of the profession throughout the State, their organization into local or district societies, as may be most convenient for them.

Fourth. That a committee be appointed to draft such resolutions, as may deserve the consideration of the Convention.

Fifth. That a committee be appointed to publish the proceedings of the Convention in pamphlet form.

The report was received, and after considerable discussion adopted. The convention proceeded to specify the number of each committee—and the following gentlemen appointed:

On the formation of a Constitution and By-laws for a State Medical Society.—Drs. J. S. Bobbs, T. Ryan, Alex. J. Mullen, N. Johnson, V. Kersey, J. Hunt, T. W. Florer, J. H. Sanders and W. C. Thompson.

On the expediency of establishing a Medical Journal.—Drs. Kersey, Mears and Curran.

On Resolutions.—Drs. Mothershead, Parry, Wallace, Ramsey, Funkhouser, Bullard and Smith.

On Printing.—Drs. Smith, Bobbs and Gaston.

Dr. Patterson offered the following resolution which was adopted:

Resolved, That a committee of five be appointed to memorialize the Legislature of the State, upon the subject of Homicidal Insanity—asking the enactment of a law requiring that in all cases where the plea of insanity is set up as an excuse for crime, the question of insanity shall be first and separately tried and decided, by a commission of lunacy.

Drs. Patterson, Parry, Mothershead, Bobbs and Dunlap, were nominated and appointed as the committee.

From the Proceedings
Indiana State Medical Convention
1849

Thus the
First Step
to organize
Hoosier Physicians
into the
INDIANA STATE MEDICAL ASSOCIATION

1849
to
1974

* Plan today, Dr. and Mrs. M.D., to attend the

125th Annual Convention

OCTOBER 4-8, 1974

Columbia Club and Convention Center
Indianapolis

•

SPECIAL PLANS
are being completed for this

Significant Anniversary Meeting

— More Details Coming —

Report

TO: All Physicians
FROM: Commission on Public Health, ISMA
Date: 8 July 1974
SUBJECT: Increasing Incidence of Venereal Disease

The Commission on Public Health, at its regular meeting on 19 May 1974, discussed the current situation regarding venereal disease. After mature consideration, it was concluded that the occurrence and age distribution were among matters for thoughtful concern by all physicians. The Commission felt it advisable to share its information with all Indiana physicians. It was noted that the situation may be more serious than is apparent from the number of reported cases.

During the last two weeks of June there were 560 new cases of gonorrhea and 55 cases of syphilis reported. In the first six months of 1974 there were 6307 cases of gonorrhea and 791 cases of syphilis diagnosed and reported. Gonorrhea has the dubious distinction of being in third place among the reportable communicable diseases. Occupying first and second are influenza and streptococcal infections, in that order.

Last year gonorrhea showed an increase of 7.5% over 1972. Comparison of the total reported cases for the first six months of 1973 and 1974 indicate that 1974 will continue the trend to increased occurrence. With these facts in mind, it was the consensus of the Commission that we need to exercise especial concern in the matter of control.

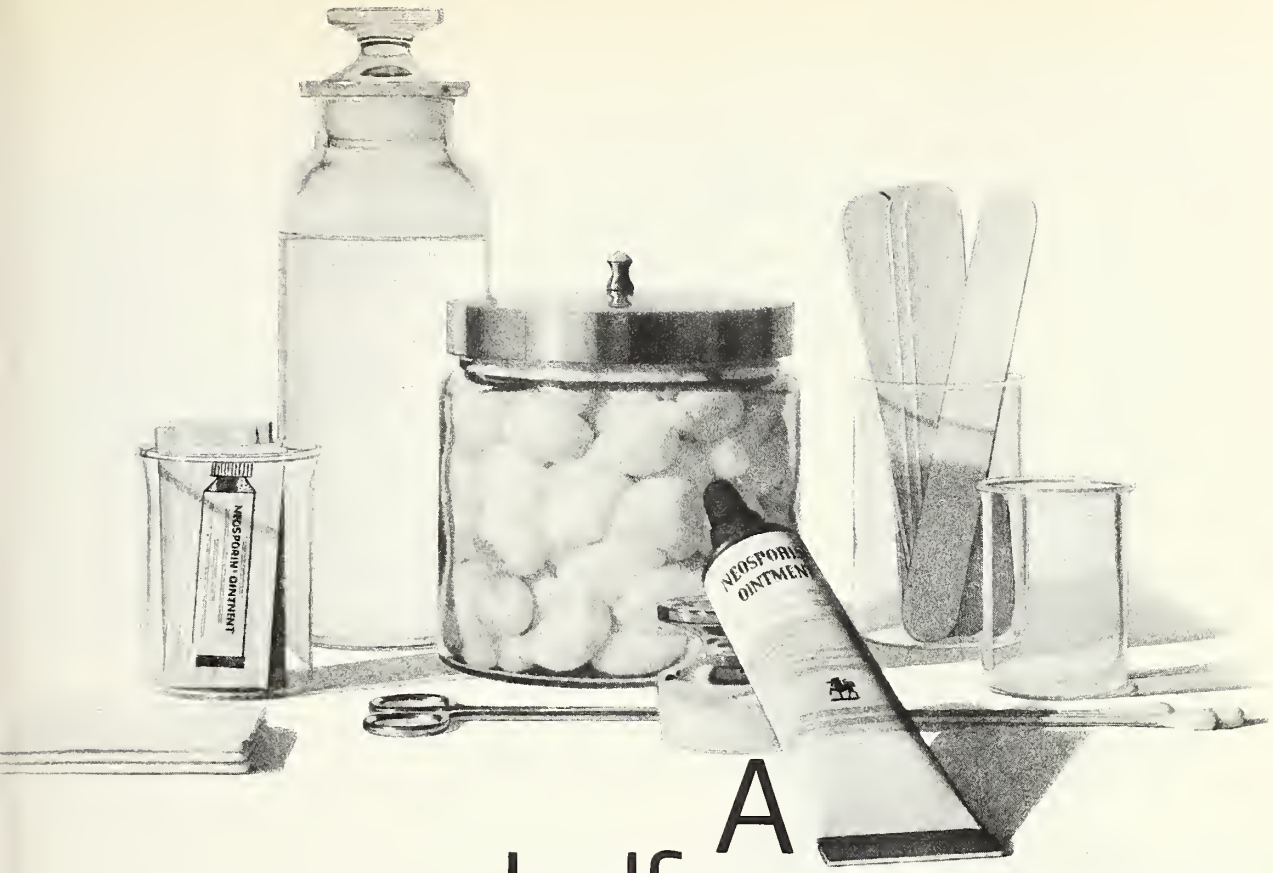
Last year the age group of 15-24, inclusive, accounted for 75% of the gonorrhea cases and 50% of the diagnosed and reported cases of primary and secondary syphilis.

Diagnosis of gonorrhea in 80% of females and 15% of males is complicated by the absence of demonstrable symptoms. In a number of cases the physician must, therefore be guided by a high "index of suspicion" and a devotion to case finding. Current relaxed behavioral standards should stimulate us to increase our efforts in control of the spread of these infections. We must be ever mindful that for each case diagnosed there is at least another case.

It is not the Commission's purpose to direct your efforts in the diagnosis and treatment of venereal diseases. One of the basic responsibilities of all physicians is to initiate, actively participate, and guide venereal disease educational programs. This responsibility we should *not* leave in the hands of others.

You can:
BE ALERT
BE ACTIVE
BE ASSIDUOUS





A half-ounce of prevention

Use it to prevent a topical infection. Or to treat one that's already started. In either case, it's good medicine. Whether for lacerations, burns, open wounds, IV catheter or surgical aftercare. Neosporin® Ointment provides broad antibacterial coverage against common susceptible pathogens. And since it contains three antibiotics that are rarely used systemically, the risk of sensitization is reduced. Neosporin Ointment. A half-ounce of prevention. Also available in a full ounce of prevention and in convenient foil packets.

Neosporin Ointment carried on Apollo and Skylab missions.

Neosporin® Ointment
(polymyxin B-bacitracin-neomycin)

Each gram contains: Aerosporin® brand Polymyxin B Sulfate 5,000 units; zinc bacitracin 400 units; neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs.
In tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

ICATIONS: *Therapeutically,* used as an adjunct to appropriate systemic rapy for topical infections, primary or secondary, due to susceptible organ- s, as in: • infected burns, skin grafts, surgical incisions, otitis externa rimary pyodermas (impetigo, ecthyma, sycosis vulgaris, paronychia) • second- rily infected dermatoses (eczema, herpes, and seborrheic dermatitis) raumatic lesions, inflamed or suppurating as a result of bacterial infection. *Prophylactically,* the ointment may be used to prevent bacterial contamination urns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts wounds accidentally incurred, its use may prevent the development of ection and permit wound healing.

NTRAINDICATIONS: Not for use in the eyes or external ear canal if the eardrum erforated. This product is contraindicated in those individuals who have wn hypersensitivity to any of the components.

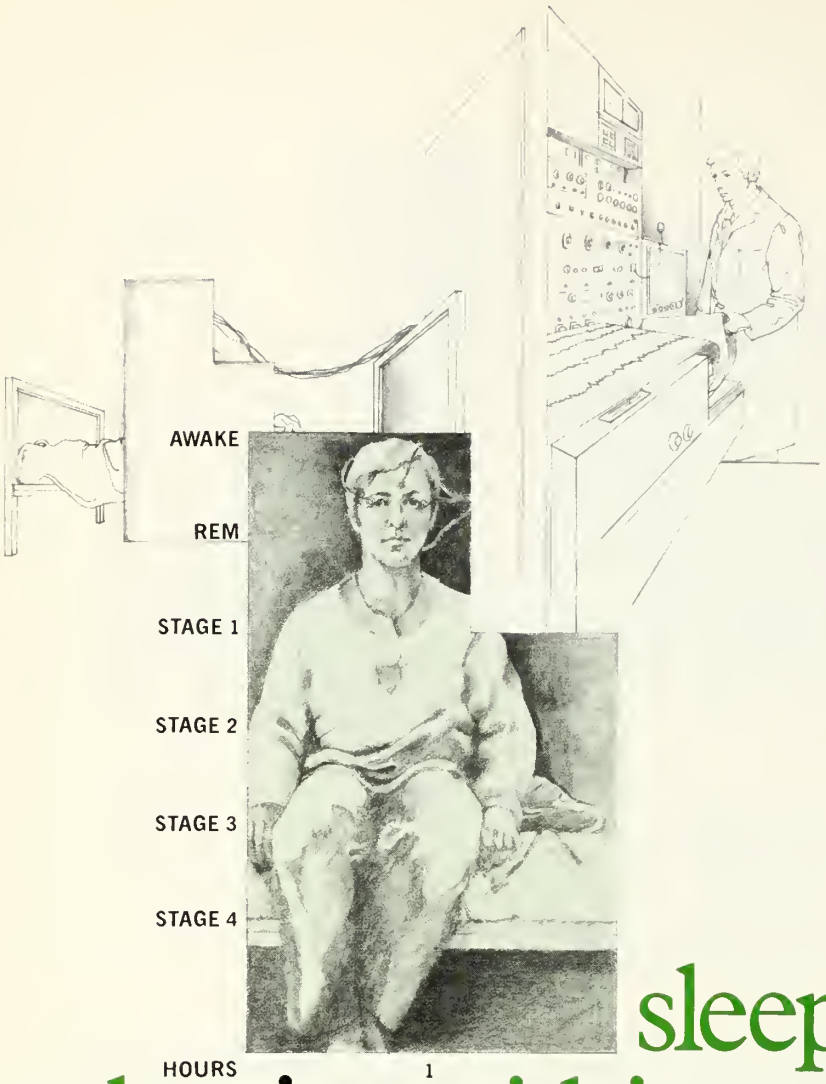
RNING: Because of the potential hazard of nephrotoxicity and ototoxicity to neomycin, care should be exercised when using this product in treating ensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

Wellcome / **Burroughs Wellcome Co.**
Research Triangle Park
North Carolina 27709



sleep begins within 17 minutes, on average ...

an initial benefit of

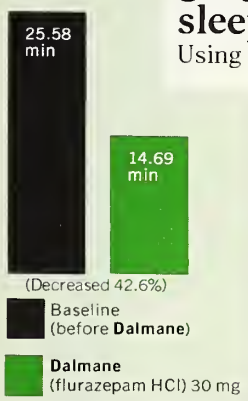
Dalmane®

(flurazepam HCl)

proved by a 22-night clinical study of insomnia patients in the sleep research laboratory and at home[1]

Three insomnia patients selected for difficulty falling asleep were administered Dalmane (flurazepam HCl) 30 mg for 14 consecutive nights. Placebo was given for four nights prior to and four nights after Dalmane. Physiologic tracings on Dalmane nights 1-3 showed sleep induction time averaged 13.90 minutes; on Dalmane nights 12-14, 18.80 minutes. Combined average for the 6 monitored drug nights was 16.35 minutes.[1]

Average Time Required to Fall Asleep (4 Studies, 16 Subjects[2-5])



confirmed by clinical studies in four geographically separated sleep research laboratories[2-5]

Using a 14-night protocol involving eight insomniac and eight normal subjects, four studies confirmed the sleep-inducing effectiveness of Dalmane (flurazepam HCl) and the reproducibility of this response. On average, one 30-mg capsule induced sleep within 17 minutes. In all these studies, Dalmane induced sleep rapidly, reduced nighttime awakenings, and provided 7 to 8 hours of sleep without repeating dosage[2-5]

Dalmane (flurazepam HCl) induces and maintains sleep, with relative safety

Dalmane is generally well tolerated; morning "hang-over" has been relatively infrequent. While dizziness, drowsiness, lightheadedness and the like have been noted most often, particularly in the elderly and debilitated, physicians should be aware of the possibility of more serious reactions, as noted below.

Before prescribing Dalmane (flurazepam HCl), please consult Complete Product Information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.

Contraindications: Known hypersensitivity to flurazepam HCl.

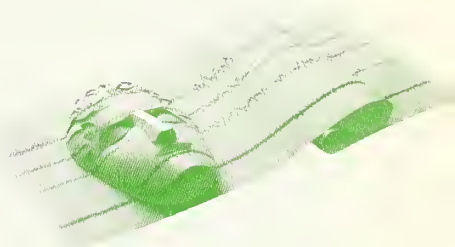
Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, have also been reported in rare instances.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.

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- sustains sleep 7 to 8 hours, on average, without repeating dosage

REFERENCES: 1. Kales A, *et al*: *Arch Gen Psychiatry 23*:226-232, Sep 1970
2. Karacan I, Williams RL, Smith JR: The sleep laboratory in the investigation of sleep and sleep disturbances. Scientific exhibit at the 124th annual meeting of the American Psychiatric Association, Washington DC, May 3-7, 1971
3. Frost JD Jr: Data on file, Medical Department, Hoffmann-La Roche Inc, Nutley NJ
4. Vogel GW: Data on file, Medical Department, Hoffmann-La Roche Inc, Nutley NJ
5. Dement WC: Data on file, Medical Department, Hoffmann-La Roche Inc, Nutley NJ

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An Acute Non-Surgical Abdomen: Henoch-Schonlein's Syndrome

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IN 1837 Schonlein described the combination of joint symptoms and rash as "peliosis rheumatica," and in 1874 Henoch added the gastrointestinal element to the disorder.[1,2] Subsequently, additional terms, including "anaphylactoid purpura," "allergic purpura," and "non-thrombopenic hypersensitivity angiitis"—with modifying age designators—have been employed.[3-7]

However, since none of the above terms specifically describes the "disease," and Henoch-Schonlein Syndrome (HSS) does the least to misdescribe it, that eponym will be utilized.

Despite the confusion in nomenclature, subjects continue to present with the disorder and can provide a rather confusing diagnostic problem if the physician does not maintain a reasonable degree of clinical suspicion.

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Case Discussion

The patient, an 18-year-old University student, was well until 12 days prior to admission, when he developed an asymptomatic "heat rash" on his feet. The lesions lasted only a few days, but recurred four days later with the development of a sore throat. Thereafter, an inflammatory arthritis evolved in the right ankle, and about 24 hours later, in the right wrist. Finally, the day before admission, he experienced nausea and vomiting, followed by an increasingly severe lower abdominal colicky discomfort—unrelieved by heat, pressure or positional alteration; but decidedly more severe after any attempted fluid intake.

His physical examination on admission revealed an acutely ill young man who manifested diffuse light-red macular eruption, most marked over the thighs and lower legs. The blood pressure was 134/88 in the right upper arm, pulse 108, and the temperature 38.4 C. Examination of his cardiovascular and pulmonary systems otherwise seemed quite unremarkable. The most sensitive area of the abdomen was in the right lower quadrant but with no definable localization beyond that. Borborygmi were hypoactive; and no pathologic masses were palpable. Ampullary examination revealed a Guaiac-positive fecal specimen.

Laboratory Data

Hemoglobin level was 15.6 gm% with a hematocrit reading of 47%. The white count was 13,000 with an essentially normal differential. The platelet count was 375,000 and his sedimentation rate was 28mm/hr (corrected). The immunoglobulin G level was increased to 3,000 mg% (with a normal for this laboratory of 600-1800 mg%); the serum complement (C'3) was 250 mg% (with a normal for this laboratory of 120-170). The remainder of the chemical and hematologic studies were negative, or within normal limits, and they included the BUN, ASO titre, electrolyte panel, latex fixation titre, EKG, blood culture, L.E. prep and ANA prep, prothrombin time, pro-



FIGURE 1
Typically appearing lesions of syndrome, as seen above, from a less frequent site of involvement—i.e., hands.

tein electrophoresis, bleeding time, clot retraction (percent and time) and Rumpel-Leede test.

Hospital Course

Initially, and for the first week of the intramural period, as the rash faded, the subject continued to experience intermittent episodes of moderately severe abdominal pain with persistent, but intermittent, vomiting. A "small intestinal series" was obtained and revealed in the terminal ileum rather marked thickening of the mucosa and loss of detail of the distal aspect of the ileum. As the young man continued to experience this abdominal pain of a rather diffuse type, and since his hemoglobin had diminished by 4 gm% during the first 72 hours of his hospitalization, consideration was given to the possibility of a "hypersensitivity disorder" of the Henoch-Schonlein variety. It seemed that, in view of the type of the vascular phenomenon he manifested externally, one would be remiss in neglecting its coexistence internally. A surgical consultant agreed with the non-operative conclusion and we initiated hydrocortisone therapy, 300 mg daily by vein, with appropriate continued I.V. fluids and ulcer precautions. Within a period of approximately a day and a half his abdominal pain and vomiting had subsided completely. The vital signs returned to normal and the subject improved dramatically. There was no indication of increased irritation of the peritoneum; nor did he manifest evidence of blood loss otherwise. He has been followed since that time as an outpatient while being maintained on oral Prednisone in slowly decremental doses—for six months—and has had no further gastrointestinal symptomology.

The patient did, however, manifest a maculopapular exanthema over the extensor aspect of the interphalangeal joint areas of the fingers in a rather selectively localized fashion (Fig. 1). There was little arthralgia; lesions would dissipate over a period of 24-36 hours, and microscopic appearance from a biopsy demonstrated non-specific focal accumulations of lymphocytes and eosinophils.

After three months, and while still on the corticoid therapy, the "periodic lesions" cleared and have not recurred. Serial small bowel x-rays have revealed complete resolution of the mucosal irregularity, and his pain in the abdomen and joints has not returned.

Discussion

Henoch-Schonlein Syndrome is thought to be a disease primarily of the capillaries; in contradistinction to a similar disorder—Polyarteritis Nodosa—which involves the medium sized arteries, primarily.[7] Although the disease usually appears in children and young adults, it may develop at any age—from infancy to the sixth or seventh decades; and the severity of the disorder in any one case seems most directly related to the age of onset.[4,6,13] The duration of the "disease" is quite variable; about one third will experience complete resolution of symptoms in one month, whereas in another third it may remain active for several months. Finally, in the last group the disorder may persist, with intermittent recurrences, for up to two years. In general, however, about one half of the patients, most frequently in the more "senior" age groups, will experience some type of recurrence.[6,8,10,13] There is no specific etiology recognized for the syndrome, but various background factors such as preceding Group-A Beta Hemolytic streptococcal infection or exposure to various antimicrobial agents have been suggested.[3,5,6] The "pertinent" laboratory findings are non-diagnostic in HSS so that the routine studies without clinical correlation would be of little assistance, except in ruling out other diseases.[6] There are, however, some important clues which can direct the physician's attention to the possibility of this entity. Dermal lesions such as petechiae, urticaria, vesicles, maculae and/or ecchymoses occur at some time in nearly all cases; and typically are more prominent over the lower rather than the upper extremities. if the lesions are distributed centripetally, one would be well-advised to consider another diagnosis.[6,9]

A second sign associated with HSS is that of soft-tissue edema which is usually restricted to the feet, hands and scalp; and occurs in about two thirds of all cases. Arthralgias—unresponsive to usual analgesic therapy—and consistently more prominent in the knees and ankles, with associated swelling of the soft tissues around the joints, have also been reported in a large percentage of cases.[6,8,13]

When gastrointestinal complaints such as colicky abdominal pain, nausea and vomiting occur, they

may mislead one to consider a primary disorder of that individual system rather than the existence of a secondary phenomenon. Particularly distressing may be the resemblance between HSS and appendicitis; regional ileitis; intramural hemorrhage —in the case of blood dyscrasias— and/or surgically oriented lesions, such as intestinal obstruction, perforation, or intussusception, since all the latter represent potentially remediable situations for management, in similiar clinical settings.[8,9,10,11,12] If x-rays are obtained, only non-specific evidence of ileal involvement is generally observed, and again further disorders of a surgical type may be mimicked.[12]

Renal involvement manifest as hematuria alone occurs rather frequently; and in addition may be associated with significant proteinuria. Only rarely in the young, otherwise benign, form of the syndrome is urgent therapy required; however, in about 10% of all cases either significant, progressive hypertension, or the evolution of a nephrotic syndrome, will dictate vigorous therapeutic efforts.

With regard to management, it is unfortunately true that the most frequent error is over-treatment. Since the natural course of the disorder is benign in the majority of cases— and especially in younger age groups—a judicious approach is particularly indicated under those circumstances.

In selected instances, steroids may be quite beneficial in permitting support temporarily; but they are not effective in reducing the total, overall mortality in any series of cases. Considering the benignity of the renal lesions, in prepubertal subjects, "expectant management" and supportive therapy alone seem indicated. However, in those presenting as "hypertensive reactors" (140-160 systolic, and above 100 diastolic) drugs such as hydralazine and/or alpha-methyl-dopa can be utilized. In subjects with a "nephrotic syndrome," administration of immunosuppressive agents appears promising; particularly since steroidal therapy, in this latter form of HSS, has no consistent beneficial effect, and certainly is not entirely innocuous.[13,14] The prime indication for steroids would appear to be in subjects with severe gastrointestinal involvement. The clinical response under those circumstances is often quite dramatic; with total relief not infrequently in the first 48 to 72 hours. If the drug is to prove effective, it will have shown its response within that interval of time, or not at all. Initial doses of glucocorticoids, such as Prednisone, should be given in 40-60 mg per day aliquots for a minimum period of at least three weeks, thereafter tapered during the course of the next five to six weeks in a slow fashion (since abrupt diminution in dosage has produced rapid recrudescence of the syndrome).

Summary

The phrase Henoch-Schonlein Syndrome (HSS) is probably the most accurate clinical and historical term for the rather ill-defined entity as noted here. It is extremely important to be aware of the variable presentations, clinical course, and finally, anticipated results, if one is to successfully manage such patients.

In general, however, treatment should be supportive except in the specific instances cited, where selective complications evolve, or the disease process is widespread and progressive. Finally, it must be emphasized to the patient, at the onset of therapy, that brief recurrences are not infrequent and the available therapy, while providing symptomatic regression, will not shorten the total duration of the disease process itself.

Acknowledgement

Grateful acknowledgement is extended to Miss Marcia Mostek, our medical secretary, without whose efforts the manuscript could not have been completed.

We also extend our appreciation to Dr. Jene Bennett and the members of the South Bend Medical Foundation for the procurement of certain special studies.

BIBLIOGRAPHY

1. Schonlein, J.L.: Allegemeine und Soecielle Pathologie und Therapie, *Berl. Klin. Wochenschr.* 2:45, 1837.
2. Henoch, E.: Ueber Eine Eigenthumliche Form Von Purpura, *Berl. Klin. Wochenschr.* 11:641, 1874.
3. Gairdner, D.: The Schonlein-Henoch Syndrome (Anaphylactoid Purpura) *Q. J. Med.* 17:95, 1948.
4. "Anaphylactoid Purpura," in *A Textbook of Pediatrics*, ed. 8; edited by Waldo Nelson: W.B. Saunders Co., 1968, Philadelphia, pp. 993-995.
5. Bowie, E.J.: Purpura—Diagnostic Possibilities; *Postgrad. Med.* 43:104-109, 1968.
6. "Allergic Purpura," in *Clinical Hematology*, ed 6; edited by Maxwell Wintrobe: Lea and Febiger, 1968, Philadelphia, pp. 912-917.
7. Norkin, S. and Weiner, J.: Henoch-Schonlein Syndrome; *Am. J. Clin. Pathol.* 33:55, 1960.
8. Stremple, J.A., et al.: The Acute Non-Surgical Abdomen of Henoch-Schonlein Syndrome, in the Elderly Patient. *Am. J. Surg.* 115:870-873, 1968.
9. Osler, W.: Visceral Lesions of Purpura and Allied Conditions. *Br. Med. J.* 1:517, 1914.
10. Steinhardt, I.D., Jonas, A.F.: Coexistence of Intussusception and Henoch's Purpura; *N. Eng. J. Med.* 257-553, 1957.
11. Balf, C.L.: The Alimentary Lesion in Anaphylactoid Purpura; *Arch. Dis. Child.* 26:20, 1951.
12. Arcomano, J.P., et al.: Schonlein-Henoch Syndrome. Roentgen Changes in the Upper GI Tract; *Am. J. Dis. Child.* 114:674-675, 1967.
13. Ballard, H.S., et al.: Renal Manifestations of Henoch-Schonlein Syndrome in Adults; *Am. J. Med.* 49: 328-335; 1970.
14. Bergstrand, A., Bergstrand, C.G., Bucht, H.: Kidney Lesions Associated with Anaphylactoid Purpura in Children; *Acta. Paediatr. Scand.* 49: 57, 1960. ◄

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Genetic Counseling at the Indiana University Medical Center

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THE Department of Medical Genetics is prepared to accept a limited number of referrals from physicians who feel that a patient may have a heritable disorder that requires confirmation, definitive diagnosis, or diagnosis and counseling. Through counseling, families and individuals receive information related to the risks inherent in the disorder itself and of the chances of its manifestations appearing in an offspring, sibling or other relative. Information is also supplied to the physician who may wish to do the counseling himself.

It should be emphasized that the Medical Genetics Clinic is a specialty clinic. If a general history and physical is necessary, this should either be performed by the private physician with results forwarded or else the patient should be evaluated in the pediatric or medical diagnostic clinic with subsequent referral to the Medical Genetics Clinic.

Resources are available to provide the complete gamut of laboratory tests required for the diagnosis of most known inherited disorders. Included are specific genotyping studies, enzyme determinations and chromosome analysis where it is indicated. A data bank of confidential information on over 325,000 individuals who may have some connection with an affected family member is stored in the departmental computer files. A similarity of family name or location within the state may suggest the presence of a disorder which otherwise eludes diagnosis and the selection of appropriate studies to confirm it.

All patients with inherited disorders can benefit from frank and open discussion of the risks of having such traits in their families. The therapy of genetic counseling following diagnostic evaluation varies markedly from family to family. Although each family has its special burden, genetic counseling does not always convey bad news. Quite the contrary, it may show minimal risk for other family members. Take the case of a child with an autosomal dominant disorder such as achondroplasia. If the biologic parents are normal, then the child's disease is the result of a new mutation. Only children of the affected patient would be at 50% risk; all other family members have a minimal risk.

While more than 2,000 inherited diseases are recorded, it is obvious that many are rare indeed. The more common referrals include such entities as cystic fibrosis, pseudohermaphroditism, hemophilia, Down syndrome, Tay-Sachs disease, sickle cell anemia, phenylketonuria or other suspected aminoaciduria, cleft lip and palate and certain cases of deafness or blindness, to mention only a few.

If a physician wishes to refer a patient to the Medical Genetics Clinic, he can do so in one of three ways. If he wishes the consultation of a particular physician in the department, he should call him directly at (317) 264-7966, describe the problem and request an appointment. He may address a letter to the chairman of the department describing the case and what is known in full detail and request an appointment. The most direct, and perhaps preferable, way is to call Ms. Ilene Page (317) 264-7966 for an appointment and follow the call with the patient's records. Sending all available information (including x-rays and laboratory results) in advance of the appointment will prevent the repetition of studies that have already been performed. When possible, patients and their families should have reviewed their family histories and have specific details such as maiden names and ages written down. The waiting list for appointments is approximately seven weeks. Emergency consultation in the event of pregnancy with possible amniocentesis for antenatal diagnosis of chromosomal disorders or selected metabolic errors will, of course, be scheduled at the most opportune time. ◄

From the Department of Medical Genetics, Indiana University School of Medicine, 1100 W. Michigan St., Indianapolis 46202.

About Our Cover

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Tumorophilic Gallium-67 Scanning: A Retrospective Study

JERRY L. KIGHT, M.D.
EUGENE VAN HOVE, M.D.
Indianapolis

FROM the beginning, clinical scintiscanning has been largely concerned with the localization of tumors. The greatest success has been achieved in scanning the brain, thyroid, liver and bone. The development of organ-specific scanning techniques and the need for a more general method of localizing tumors led to the hope that a radioactive pharmaceutical could be found that would concentrate in all tumors regardless of type or location. Gallium-67 is this type of radiopharmaceutical.

Dudley and Maddox first reported localization of gallium citrate in bone in 1949.[1] Hayes and Edwards, in the late 1960s were evaluating Gallium-67 as a possible bone scanning agent.[2] They observed a concentration of Gallium-67 in a non-osseous tumor in a patient with Hodgkin's disease. Higashi and his group,[3] in 1972, postulated that the uptake was probably due to difference in permeability of tumor cell membranes as compared to normal cells while Edwards and Hayes[2] postulated a substance in higher concentration within the normal cell. The Higashi group also showed an increased uptake in active granulomas as well as benign and malignant tumors. They found increased concentrations in the granulocytic series of these patients.

Although the actual mechanism of tumorophilic activity is not understood, some of the mammalian cellular activity is. The bulk of the ^{67}Ga enters the cell by passive diffusion while a small portion enters by active transfer. Electron microscopy has shown ^{67}Ga predominantly in heterogenous electron-dense bodies in the cytoplasm. A single membrane usually surrounds these dense bodies.[4] The sites that localize the activity appear to be lysosomes or places of lysosomal activity.

Gallium-67 is cyclotron produced by the bombardment of zinc with protons. At the same time, large amounts of short lived ^{66}Ga and ^{65}Ga are produced. However, five days after bombardment, the product contains no ^{65}Ga, less than 0.5% ^{66}Ga, and 0.04% ^{67}Zn per unit of ^{67}Ga. Gallium can also be pile produced. The critical organ in gallium scanning is the bone marrow with a dose of 1.60 rads per mCi as determined by the absorbed dose method and published equilibrium dose constants in conjunction with in vivo distribution data.[6]

Figure 1 outlines the normal distribution within the body. We find early nasopharyngeal activity which usually disappears within 24 hours.

Study Protocol

Our patients were referred by a group of oncologists primarily for the staging of Hodgkin's disease. All adult patients were given 3-5 mCi of ^{67}Ga citrate, intravenously. Initially, the patients were scanned at 24, 48, 72 hours and longer, as indicated. Now, all patients are scanned at 48 and 72 hours unless otherwise indicated. Anterior and posterior whole body scans are done with a 5″ dual probe rectilinear scanner. Bowel preparations are given at 24 and 48 hours to clear the normal bowel activity. The 93, 184 and 296 KEV peaks are summated.

Discussion

As the cases presented show, Gallium-67 is not a tumor-specific scanning agent. Increased activity can be seen as an early, normal find-



FIGURE 1
A 24-hour anterior whole body scan showing the normal nasopharyngeal, sternal and liver activities. The bowel was well prepared and bowel activity is not seen.

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Study made possible by a grant from "The Little Red Door," Marion County Cancer Society, Inc.

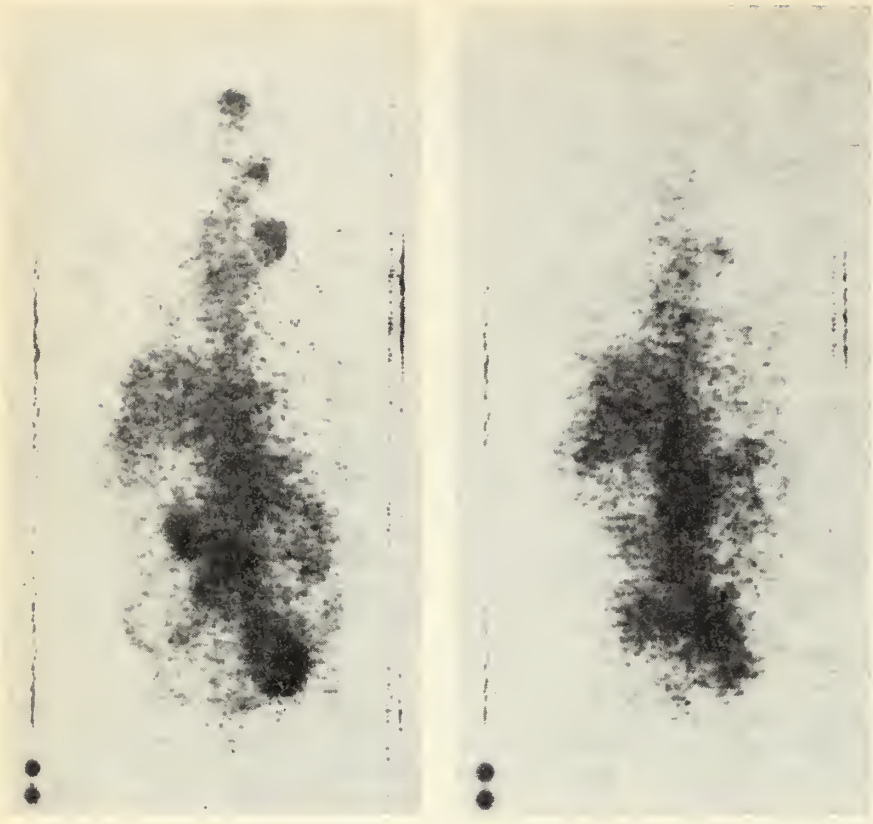


FIGURE 2A AND B

Forty-eight hour anterior and posterior whole body scans: (a) anterior, ond (b) posterior. This 56-year-old male was admitted for the staging of lymphoma. There is abnormal localization in the nasopharynx, left cervical, left supraclavicular, periaortic, ilian and left inguinal nodes. All areas are revealed on the anterior view.



FIGURE 3B

Anterior and right lateral Technetium sulfur colloid liver scan. Metastatic disease of the liver was evident with Technetium, only suspected with Gallium.

ing in the nasopharynx and must not be interpreted as supraclavicular or cervical adenopathy. The incidence of the retro-orbital activity, as demonstrated in Figure 5, is varied depending upon the series reported. The exact site of localization is not known nor is the mechanism; although it is generally agreed that this is a normal variant. A positive Gallium-67 scan can be seen not only in malignant tumors but in any condition which will cause a stimu-

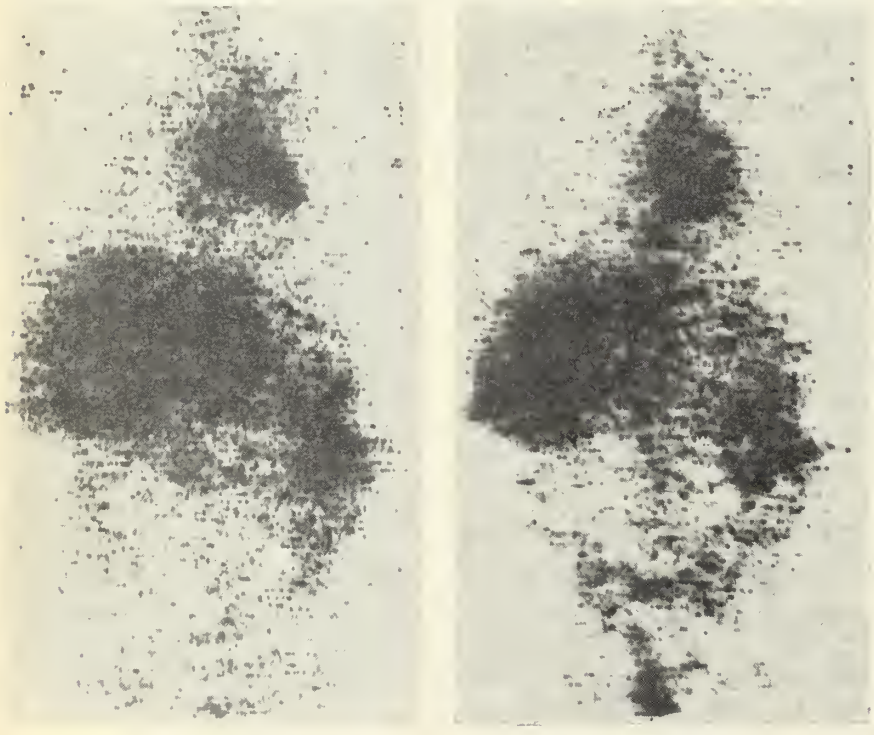




FIGURE 3A

Forty-eight hour anterior and posterior whole body Gallium-67 scans. This is a case of bronchogenic carcinoma with liver metastases. There is increased uptake in the left perihilar and mediastinal areas secondary to the bronchogenic carcinoma. This correlates well with the PA chest film. There is some activity seen in the bowel.

TABLE I

	NO. OF CASES	CLINICAL-SCAN AGREE-MENT	ON THERAPY	MISSED
Hodgkin's Disease	20	17	2	1
Other Lymphomas	8	5	1	2
Lymphoid Hyperplasia	6	6	—	—
Lung Cancer	8	6	1	—
Other	8	6	1	1

lation of the granulocytic series (benign tumors and infection).

Table 1 is a summary of the first 50 cases done in our department. These were all done in patients in which lymphoma was suspected and staging was desired. The percentage of agreement between the clinical diagnosis and the scan for the whole series was 80%. The incidence of false negative scans is increased if the patient has had radiation or is on chemotherapy for the disease process. If these cases are removed, the percentage agreement increased to 90%.

With those cases of treated disease removed from the study, the percentage of agreement is: (1) Hodgkin's disease—94%; (2) Other lymphomas—70%; (3) Bronchogenic carcinoma—85%; (4) other lesions—85%; (5) Lymphoid hyperplasia—100%. This latter figure was a surprising and very interesting finding.

The advantages of using Gallium in the diagnosis and staging of Hodgkin's disease include a direct visualization of the tumor. The procedure is simple to perform and safe for the patient. There is a very low dose total body radiation with the critical organ being the bone marrow. The radiation dose to the bone marrow is well within safety limits.

The disadvantages include the cost and the procedure time. Modification of the rectilinear scanner is essential because there are three energy peaks to the ^{67}Ga and the three lower peaks must be summated. Special licensure is required for the use of Gallium and any radiation or chemotherapy the patient has undergone will lead to false negative results.





FIGURE 5A AND B

Seventy-two hour anterior whole body Gallium-67 scan. The activity in the left hilar area correlates well with the lesion seen on the PA chest film. The retro-orbital activity is a normal variant. This was a benign thymoma.



FIGURE 4

Ninety-six hour, anterior Gallium-67 whole body scan. There is right hilar, mediastinal and left apical activity. There was increasing activity diffusely scattered throughout the abdomen on the serial scans. This is an example of positive Gallium scan in a patient with tuberculous peritonitis and pulmonary tuberculosis.

Summary

The first 50 patients referred for the staging of Hodgkin's disease have been studied in retrospect.

Serial anterior and posterior Gallium-67 whole body scans were done. Gallium was found to localize not only in malignant tumors but in benign lesions and infectious processes as well. Gallium-67, therefore, is not the ultimate radionuclide for tumorophilic scanning, since it is not entirely tumor-specific. However, the results, when correlated with the clinical and pathological findings, were encouraging. Gallium scanning is now becoming a part of the routine work-up for such entities as lymphoma, bronchogenic carcinoma, and other high grade malignancies. Further study of patients with bronchogenic carcinoma to determine operability prior to surgery is now being evaluated.

BIBLIOGRAPHY

1. Dudley, H.C.; Maddox, G.E.; LaRue, H.C.: Studies of metabolism of gallium. *J. Pharmacol. Exp. Ther.* 96: 135-138, 1949.
2. Edwards, C. Lowell; Hayes, Raymond L.: Scanning malignant neoplasms with gallium-67. *JAMA* 212:1182-1190, May 18, 1970.
3. Higashi, et al: Clinical evaluation of 67-gallium citrate scanning. *J. Nuel. Med.* 13:196-201, 1972.
4. Swartzendruber, D.C.; Nelson, B.; Hayes, R.L.: Gallium-67 localization in lysosomal-like granules of leukemia and nonleukemic murine tissues. *J. Natl. Cancer Inst.* 46:941-952, 1971.
5. Langhammer, H., et al: 67-gallium for tumor scanning. *J. Nuel. Med.* 13:25-30, 1972.
6. Cloutier, R.J.; Watson, Evelyn E.; Hayes, R.L., et al: Radiation doses from isotopes of gallium (abstract). *J. Nucl. Med.* 12:348, 1971. ◄

From THE JOURNAL 50 Years Ago

What we may term the chemical treatment of chronic empyema, used deliberately for the purpose of replacing thoracoplasty, is of a very recent origin. Gibbon credits Depage of Brussels, with having devised it, and Tuffier with having demonstrated, in February 1918, a series of 25 cases successfully so treated. Heuer, however, was acquainted with the principle of the method as early as 1913, and was first in this country to publish results obtained therewith. . . .

On the patients here reported I used in nearly every case chlorazene solution of a strength of from two per cent to five per cent. In one cavity I used an aqueous solution of gentian violet. The latter probably would have been very beneficial for all the cases complicated by bronchial fistula.

I treated my first case by the chemical method in August 1920. Up to that time I had been frankly skeptical as to its merits, having seen disastrous results follow efforts to sterilize, without adequate drainage, acute empyema cavities. . . .

Of 21 cases of chronic empyema I have succeeded in closing 17 by the use of the so-called chemical method. Two cases have died, but neither from causes in any way connected with the treatment. One patient with tuberculosis still has a small sinus, but is able to work and earn a living. One case required a small, and one a large thoracoplasty.

The treatment employed has been demonstrated to be devoid of danger, and is easily carried out. The strong chlorinated solution rapidly sterilizes the cavity and destroys the thick walls of the same at a rate which is not too rapid for safety. It also opens up pockets of pus not draining freely into the main cavity. . . . W. D. Gatch, M.D., Indianapolis, "The Closure of Chronic Empyema Cavities by Chemical Treatment," **JISMA**, September 1924.

Synthroid®

(sodium levothyroxine)

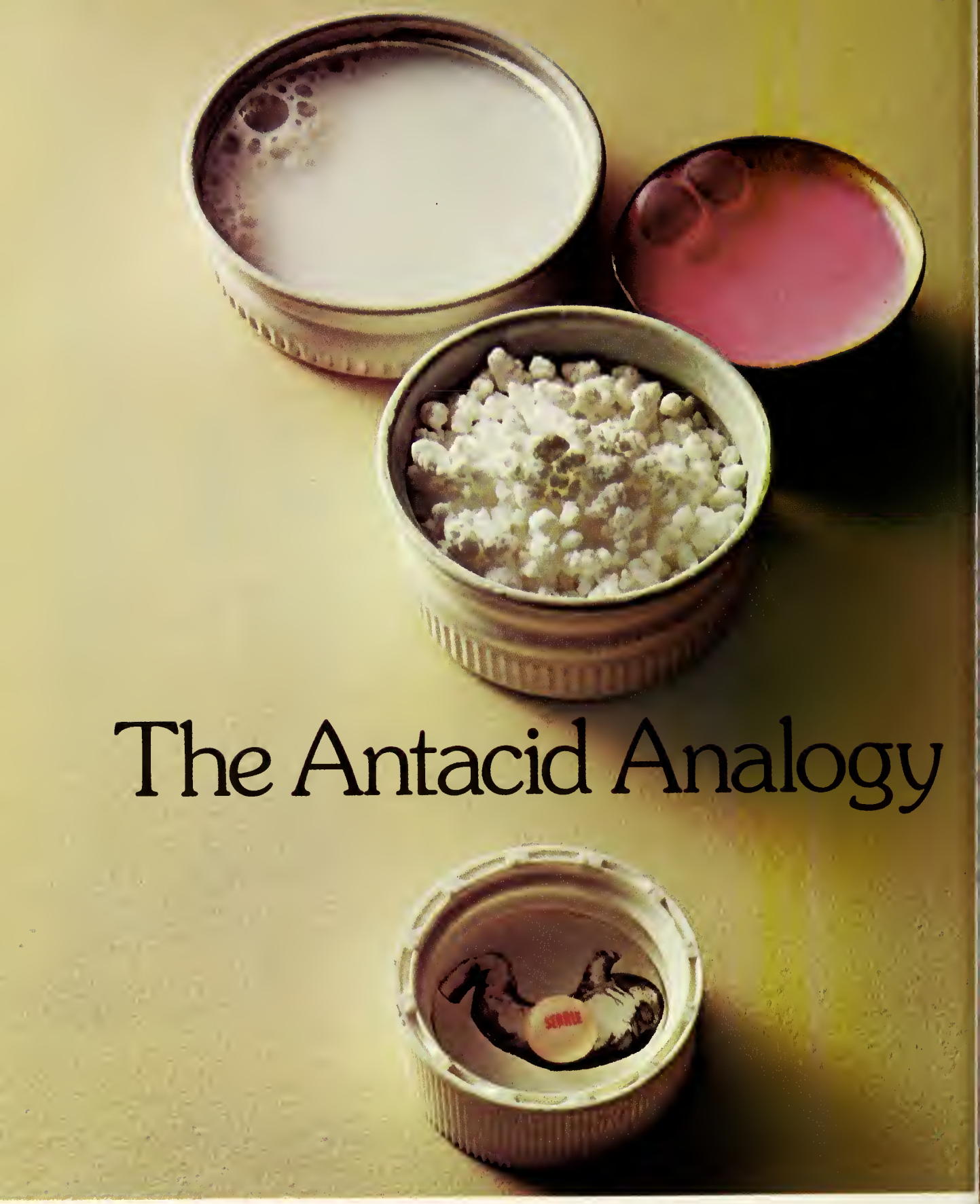


Supplied: **Tablets:** 0.025 mg., 0.05 mg., 0.1 mg., 0.15 mg., 0.2 mg., 0.3 mg., 0.5 mg., scored and color-coded in bottles of 100, 500, and 1000.

Injection: 500 mcg. lyophilized active ingredient and 10 mg. of Mannitol, U.S.P., in 10 ml. single-dose vial, with 5 ml. vial of Sodium Chloride Injection, U.S.P., as a diluent.

Synthroid-T_4

FLINT LABORATORIES
DIVISION OF TRAVENOL LABORATORIES, INC.
Deerfield, Illinois 60015



The Antacid Analogy

Indications: Pro-Banthine is effective as adjunctive therapy in the treatment of peptic ulcer. Dosage must be adjusted to the individual.

Contraindications: Glaucoma, obstructive disease of the gastrointestinal tract, obstructive uropathy, intestinal atony, toxic megacolon, hiatal hernia associated with reflux esophagitis, or unstable cardiovascular adjustment in acute hemorrhage.

Warnings: Patients with severe cardiac disease should be given this medication with caution.

Fever and possibly heat stroke may occur due to anhidrosis.

In theory a curare-like action may occur, with loss of voluntary muscle control. For such patients prompt and continuing artificial respirati should be applied until the drug effect has been exhausted.

Diarrhea in an ileostomy patient may indicate obstruction, and t possibility should be considered before administering Pro-Banthine.

Precautions: Since varying degrees of urinary hesitancy may be evidenc by elderly males with prostatic hypertrophy, such patients should advised to micturate at the time of taking the medication.

Overdosage should be avoided in patients severely ill with ulcerati colitis.

Adverse Reactions: Varying degrees of drying of salivary secretions m

Therapeutic comparisons in peptic ulcer.

Antacids have only one mode of action to relieve ulcer pain...

Pro-Banthine® has four.

and of
propantheline bromide

Antacids:

Antacids relieve ulcer pain by neutralizing gastric acid. This action is relatively short-lived and they have no other mode of action.

Pro-Banthine:

Pro-Banthine suppresses gastric acid secretion. The antisecretory properties of Pro-Banthine are well established. By effectively blocking vagotonic impulses Pro-Banthine suppresses gastric secretion to reduce both total and free acid.

Pro-Banthine helps relieve pain. Pro-Banthine relieves ulcer pain by reducing gastric secretion and the motility and spasm of the gastrointestinal tract.

Pro-Banthine reduces acidity without subsequent acid rebound. The capacity of Pro-Banthine to reduce the secretion of total and free acid in the stomach has been demonstrated in scores of studies. None has demonstrated any significant evidence of acid rebound.

Pro-Banthine activity lasts about six hours. The effect of a single therapeutic dose (15 mg.) of Pro-Banthine lasts about six hours.* Pro-Banthine P.A.®, the prolonged-acting form, is active from 8 to 12 hours. Thus Pro-Banthine may be used to suppress acid, spasm, and pain around the clock, even during the sleeping hours when antacids, to be effective, must be taken almost hourly.

*Innes, I. R., and Nickerson, M., in Goodman, L. S., and Gilman, A. (editors): The Pharmacological Basis of Therapeutics, ed. 4, New York, The Macmillan Company, 1970, p. 537.

Pro-Banthine complements and enhances the action of antacids.

SEARLE **Searle & Co.**
San Juan, Puerto Rico 00936

Address medical inquiries to: G. D. Searle & Co.
Medical Department, Box 5110, Chicago, Ill. 60680

cur as well as mydriasis and blurred vision. In addition the following verse reactions have been reported: nervousness, drowsiness, dizziness, omnia, headache, loss of the sense of taste, nausea, vomiting, constipa-n, impotence and allergic dermatitis.

sage and Administration: The recommended daily dosage for adult l therapy is one 15-mg. tablet with meals and two at bedtime. Subse-ent adjustment to the patient's requirements and tolerance must be de.

o-Banthine P.A.—Each tablet of Pro-Banthine P.A. (propantheline omide) contains 30 mg. of the drug in the form of sustained-release or timed-release beads; on ingestion about half of the drug is released within an hour and the remainder continuously as earlier increments are metabolized. Thus the result is even, high-level anticholinergic activity maintained all day and all night in most patients with only two tablets daily. Some patients may require one tablet every eight hours.

The contraindications and precautions applicable to Pro-Banthine 15 mg. should be observed.

How Supplied: Pro-Banthine is supplied as tablets of 15 and 7.5 mg., as prolonged-acting tablets of 30 mg. and, for parenteral use, as serum-type vials of 30 mg.

The Role of the Detail Man

Opinion & Dialogue

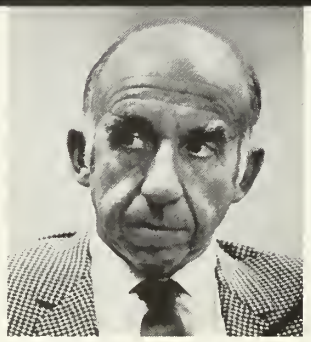


Dr. Willard Gobbell
Family Physician
Encino, California

"I may be prejudiced, but I am very much in favor of the detail men I meet. Most of them are knowledgeable about the drugs they promote and can be a great help in acquainting me with new medication."

Family Physician's Perception

I think that most general practitioners in this area feel as I do about the detail man. Over the years I have gotten to know most of the men who visit me regularly and they in turn have become aware of my particular interests and the nature of my practice. They, therefore, limit their discussion as much as possible to the areas of interest to me. Since I usually see the same representative again in future visits, it is in his best interest to supply me with the most honest, factual, as well as up-to-date information about his products.



Dr. Jeremiah Stamler
Chairman
Department of Community Health and Preventive Medicine, and Dingman Professor of Cardiology
Northwestern University Medical School

"In the total picture of dealing with health problems in this country, there is a potential for detail men to play a meaningful role."

The Positive Influence

My contact with representatives and salesmen of the pharmaceutical industry is the type of contact that people in a medical center, research people, and academic people have and that's in all likelihood on a somewhat different level from that of the practicing physician.

Let me touch on how I personally perceive the role of the sales representative. These men reach large numbers of health professionals. Thus they could be—and at times actually are—disseminators of useful information. They could consistently serve a real educational function in their ability to discuss their products.

At present they do distribute printed material, brochures and pamphlets—some of it scientifically sound and therefore truly useful—as well as some excellent films produced by the pharmaceutical industry. When they function in this

Is He a Source of Information?

Yes, with certain reservations. The average sales representative has a great fund of information about the drug products he is responsible for. He is usually able to answer most questions fully and intelligently. He can also supply reprints of articles that contain a great deal of information. Here, too, I exercise some caution. I usually accept most of the statements and opinions that I find in the papers and studies which come from the larger teaching facilities. It goes without saying that a physician should also rely on other sources for his information on pharmacology.

Training of Sales Representatives

Ideally, a candidate for the position as a sales representative of a pharmaceutical company should be a graduate pharmacist who has a questioning mind. I don't think this is possible in every case, and so it becomes the responsibility of the pharmaceutical company to train these individuals comprehensively. It is of very great importance that the detail man's knowledge of the product he represents be constantly reviewed as well as updated. This phase of the sales representative's education should be a major responsibility of the medical department of the pharmaceutical company.

I am certain that most of these companies take special care to give their detail men a great deal of information about the products they produce—information about indications, contraindications, side effects and precautions. Yet, although most of the detail men are well informed, some, unfortunately, are not. It might be helpful if sales representatives were reassessed every few years to determine whether or not they are able to fulfill their important function. Incidentally, I feel the same way about periodic assessments of everyone in the health care field, whether they be general practitioners, surgeons or salesmen.

Value of Sampling

I personally am in favor of limited sampling. I do not use sampling in order to perform clinical testing of a drug. I feel that drug testing should rightly be left to the pharmacology researcher and to the large teaching institutions where such testing can be done in a controlled environment.

I do not use samples as a "starter dose" for my patients. I do, however, find samples of drugs to be of value in that they permit me to see what the particular medication looks like. I get to see the various forms of the particular medication at first hand, and if it is in a liquid form I take the time to taste it. In that way I am able to give my patients more complete information about the particular medications that I prescribe for them.

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capacity they are indeed useful; particularly in the fact that they disseminate broadly based educational material and serve not just as "pushers" of their drugs.

The Other Side of the Coin

Obviously, the pharmaceutical companies are not producing all this material as a labor of love—they are in the business of selling products for profit. In this regard the ambitious and improperly motivated sales representative can exert a negative influence on the practicing physician, both by presenting a one-sided picture of his product, and by encouraging the practitioner to depend too heavily on drugs for his total therapy. In these ways, the salesman has often distorted objective reality and undermined his potential role as an educator.

The Industry Responsibility

Since the detail man must be an information resource as well as a representative of his particular pharmaceutical company, he should be carefully selected and thoroughly trained. That training, perforce, must be an ongoing one. There must be a continuing battle within and with the pharmaceutical industry for high quality not only in the selection and training of its sales representatives, but also in the development of all of its promotional and educational material.

The industry must be ready to accept constructive as well as corrective criticism from experts in the field and consumer spokesmen, and be willing to accept independent peer review. The better educated and prepared the salesman is, the more medically accurate his materials, the better off the pharmaceutical industry, health professionals and the public—*i.e.*, the patients—will be.

Physician Responsibility

The practicing physician is in constant need of up-dated information on therapeutics, including drugs. He should and does make use of drug information and answers to specific questions supplied by the pharmaceutical representative. However, that information must not be his main source of continuing education. The practitioner must keep up with what is current by making use of scientific journals, refresher courses, and information received at scientific meetings.

The practicing physician not only has the right, but has the responsibility to demand that the pharmaceutical company and its representatives supply a high level of valid and useful information. I feel certain that if such a high level is demanded by the physician as well as the public, this demand will be met by an alert and concerned pharmaceutical industry.

From my experience, my impression is that sectors of the pharmaceutical industry are indeed ethical. I challenge the industry as a whole to live up to that word in its finest sense.

Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005

P·M·A



PLEASE CALL US—a program to assist cancer patients and family members—will be implemented throughout the state on October 1. This is a new service provided for the cancer patient in his home.

Volunteers involved in the PCU program are rehabilitated cancer patients, family members of cancer patients or persons who have been closely associated with the care of cancer patients. To qualify for training, a volunteer must have been specially selected, screened and have one medical referral and one acquaintance referral. After completing a structured training conducted by medical professionals, a volunteer is certified to give requested services and assistance to cancer patients and families.

Numerous helps can be given—locating a hospital bed for use in the patient's home; finding a sitter to stay with the patient when other members of the home need to be away; calling a member of the community to provide transportation to and from the hospital or doctor for cancer therapy; acquiring financial information; grocery shopping for the family—providing help for any request which will ease the stress on the patient and family.

Each ACS county Unit will implement a PCU program according to the facilities available in the community. Utilization of existing voluntary and official organizations which provide a variety of aids will produce a consolidation of community resources.

The county PCU Program will be organized by an Advisory Committee. Members are a Nurse as Chairman, Medical Doctor, Clergyman, Qualified Counselor, Hospital Representative and Volunteer. The purpose of the Advisory Committee is to supervise the workings of the PCU program as well as to select and train volunteers involved in the program.

The objective of the PCU Program is to enhance quality care for the cancer patient and/or family members within the community.

PLEASE CALL US

(For further information about PCU in your community, call your local ACS.)

NATIONAL CONFERENCE ON ADVANCES IN CANCER MANAGEMENT, PART I: TREATMENT AND REHABILITATION

—sponsored by the ACS and the National Cancer Institute

WHEN: Nov. 25, 26, 27

WHERE: Waldorf-Astoria Hotel, New York City

PURPOSE: Advances in cancer treatment and rehabilitation can improve the survival and quality of life for the cancer patient when properly employed by the medical and related health professions. Leading authorities will present the latest developments in surgery, radiation therapy, chemotherapy and immunotherapy and supportive techniques for the optimum treatment of specific cancers. Advances in rehabilitation will demonstrate the improvement in the quality of survival that can be achieved at the present time.

Advanced registration is requested. There is no registration fee. Send name, address and title of specialty area to Sidney L. Arje, M.D., ACS, Inc., 219 E. 42nd Street, New York, N.Y. 10017. Hotel reservations should be made directly with the Waldorf-Astoria Hotel. Additional information can be obtained from your county ACS Unit or write the Indiana Division of ACS (above address).

Monday, Nov. 25, Sessions
9:00 a.m.—12:30 noon

COMBINING TALENTS FOR THE MANAGEMENT OF CANCER PATIENTS: BREAST CANCER AND GYNECOLOGIC CANCER

2:00 p.m.—5:00 p.m.

CANCER OF THE GASTROINTESTINAL TRACT: PANCREAS AND LIVER; COLON AND RECTUM CANCER

Tuesday, Nov. 26, Sessions
9:00 a.m.—12:00 noon

UROLOGIC CANCER; HEAD AND NECK CANCER

2:00 p.m.—5:00 p.m.

SARCOMAS AND MELANOMA; CANCER OF THE LUNG AND BRAIN

Wednesday, Nov. 27, Session
9:00 a.m.—12:00 noon

LEUKEMIAS AND LYMPHOMAS: FUTURE PROSPECTS: Patient Employability-Insurability; Patient Support Systems; Immunotherapy; and Particle Therapy.

This Continuing Medical Education activity is acceptable for 15 hours of credit in Category I for the Physician's Recognition Award of the AMA; 15 hours of credit by the American Academy of Family Physicians.

CHANGES IN MEDICARE COVERAGE

The Social Security Administration has modified its policy and now approves payment for breast prostheses when reviewing Medicare claims.

Also, "colostomy supplies" has been revised to "include other ostomies."

Further details can be obtained from your local Social Security Administration Office.

WILLIAM M. DUGAN, JR., M.D.
Chairman of Professional Education
Indiana Division
American Cancer Society, Inc.

The Journal
of the INDIANA STATE MEDICAL ASSOCIATION

Devoted to the interests of the medical profession of Indiana

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3935 N. Meridian, Indianapolis, Indiana 46208

The Problem of Drug Inequivalence Is Real

The low-cost drug reimbursement plan for Medicare and Medicaid is still alive and getting stronger. This despite a clearly worded report from the Office of Technology Assessment that "the problem of drug inequivalence is real," and that "until stringent new criteria are met, drug problem equivalency cannot be assured."

The FDA cannot now, and cannot for some time to come, assure the bioequivalence of all drug products. The problem of equivalence is not critical in many drugs. But it is critical in many drugs and usually these are the ones where bioequivalency is the most important. Digitalis is a good example.

The immediate problem for clinicians is to try to save a few patients' lives in spite of a penny-pinching government program.

The long term problem is different and a lot more serious. What the government is doing is eliminating quality as a selling point for drugs and substituting price.

No pharmaceutical manufacturer will, under the proposed policy, be able to maintain high quality and, at the same time, compete in price with another maker who is willing to make drugs more cheaply and with less quality.

Nothing was ever made in this world so cheaply that someone else would not make it more cheaply and sell it for less.

If the present government policy continues for long, high quality drugs will disappear from the market.

Dr. Wunderlich Comments

EDWIN E. Wunderlich, M.D., a graduate of Indiana University School of Medicine, is just finishing his year as president of the Los Angeles County Medical Association. In his last President's Page, Dr. Wunderlich comments on the assaults against private practice and the proper practice of medicine with some thought that our side may have made some good points this past year. He speaks of politicians as follows:

(1) When they say they want medical care for all the people, we say we want *quality medical care* for all the people, and we, the doctors, not the politicians, know what quality is.

(2) When they say they want cheaper medical care and only government can provide it, we say the only possible way government can provide cheaper medical care is by providing poorer care and less care We back our position by pointing out fixed costs that are tied to inflation with the mandatory additional cost of a bureaucratic administrative superstructure. All of this will be paid for from your taxes, of course.

(3) They say group practice of the prepaid health plan type will give broader and cheaper care, and they pass laws to subsidize this method of medical care delivery. We say, two independent studies, one by HEW and one by Rand Corporation, already document that this type plan costs more than private practice and gives less care per dollar spent. In addition, capitation type reimbursement demands rigid cost control procedures which negate the possibility of preventive medical care.

(4) They say they have concern for the people, the poor, the old, the little guy, and they propose and promise a medical utopia by feeding them all into a giant government medical monopoly designed by systems analysts, staffed by bureaucrats, controlled by averages and standards for treatment which will be derived from the most modern and efficient computer data analysis. This, they say, is what the people want.

We say, . . . we have been demonstrating our concern for the people, . . . in thousands of human-scale offices and hospitals staffed by doctors who treat people as unique individuals . . .

This, we say, the people have, and they won't give it up if they know the truth behind the myths of government and social medical systems.

The 14-Point Scale for Health Care

WHEN the Senate Finance Committee began hearings on national health insurance, Senator Vance Hartke made an opening statement, a portion of which is reproduced below:

Basic Principles For National Health Insurance

These hearings afford an opportunity to discuss the basic elements which must be a part of national health insurance. Let me suggest what I believe those elements to be.

First, good health is the hope of every American and access to quality health care is the right of every American. National health insurance must guarantee that right.

Second, there are Americans who, because of income, employment status, or geographic location, do not have sufficient access to quality health care. National health insurance must guarantee that access.

Third, national health insurance must cover the costs of preventive as well as remedial care.

Fourth, it must cover the cost of hospitals and health care practitioners.

Fifth, it must cover the costs of both short term illnesses and long term sickness and debilitation.

Sixth, it must cover the costs of home health care and mental health care.

Seventh, it must allow patients to choose their own doctors.

Eighth, it must provide a means to establish a system of health insurance coverage for lower income individuals and families.

Ninth, it must not differentiate between the scope of coverage afforded to the poor and the non-poor.

Tenth, it must not provide for any unnecessary governmental intervention in the health care delivery or insurance system.

Eleventh, it must seek to avoid unnecessary paper work, regulations or other complications which only serve to inhibit the provision of quality health care and heighten suspicion and frustration among the people.

Twelfth, the extent of finacial assistance provided by the Federal government should be related in a rational and responsible manner to family income. In other words, those most in need should get the most financial assistance.

Thirteenth, national health insurance must provide expanded benefits for those 65 and older which are similar, if not identical, to those provided for people under 65.

Fourteenth, it must include reasonable provisions for cost control and utilization review.

These are the basic principles which must be a part of any national health insurance policy. To them, I add a word of caution. National health insurance is more than a matter of political importance. Millions of Americans will benefit from it, but they will not get that benefit if we enact a program which promises far more than it can deliver. We must look at the present capabilities of our own health care delivery system before we enact any program which is designed to encourage a major increase in the use of that system. We must look to the national health programs of other countries, so that we can adopt their strengths and avoid their pitfalls.

Each of the 14 points by itself sounds reasonable and feasible. The catch is that many of these fine principles are mutually antagonistic, like the two about less paper work and cost control. Every doctor knows you can't have both.

And the combination of no governmental intervention and the promise to provide quality care to every American everywhere in the country.

And even more unusual is the incompatibility of the basic reason for national health insurance (stated elsewhere in Senator Hartke's statement as the necessity of lowering the total cost of American health care) and the utopian magnificence of health care as outlined in the 14 points. Health care on the "14-point scale" will double or triple our health expenditures. Or else it will lower the quality of care to a mediocre level.

Implicit in Senator Hartke's statement is the assumption that poor people get poor medical care because they are poor. Most of the lack of good care in this country is because people violate the rules of hygiene, pay no attention to preventive measures, go to the doctor late if at all, and then pay little attention to good advice.

Senate Bill 3441

Senator Kennedy has introduced Senate Bill 3441 entitled the Drug Utilization Improvement Bill.

The Bill has been characterized by an outside critic as being based on "an *a priori* presumption that there is widespread overuse, misuse and abuse of prescription pharmaceuticals and that thousands die as a result. It calls for federal intervention to prevent such abuses."

The Bill would establish a National Center for Clinical Pharmacology for support of education and graduate training and to make grants to entities whose purpose would be to demonstrate new roles in clinical pharmacology. HEW has already testified that the department sees no need for such a center since such activities already exist.

An adverse drug reaction program would be set up on a budget of $6 million for two years. The HEW Secretary would be required to recommend a drug safety assurance plan to curb improper prescribing. Drug detail personnel could be placed under government control by this measure. HEW says that this program is an extension of existing HEW activities.

The Bill would ban any gift or anything of value given to influence the use of a drug. Educational articles would be excepted. Samples would be limited to use in clinical research or for indigent patients and written requests would be required. Both HEW and the Pharmaceutical Manufacturers Association have already strongly promoted these principles. HEW strongly advocates the giving of starter samples.

The Bill would require manufacturers and distributors to include price information in advertisements, and the retail pharmacist to post drug prices as well as the pharmacy markup. This provision would preempt state laws to the contrary.

HEW certification of training programs for detailmen would be required. HEW says that, while improved training is desirable, FDA should not be expected to monitor the process.

A National Drug Compendium is prescribed by the Bill. HEW states that it has ample authority to proceed with a compendium.

The Bill would also mandate the addition to any drug label of a brief summary of side effects, etc., understandable by the consumer.

One of the "remedies" for alleged drug misuse, as specified in the Bill, would be additional controls over distribution and use of drugs with a high rate of misuse. This provision might limit the distribution of certain drugs to hospitals. It might also specify that some physicians could prescribe the designated drugs; other physicians could not.

The hearings upon which the Bill is based were structured on the familiar plan of deciding what the findings should be and then inviting carefully chosen witnesses whose testimony could be predicted as favorable to the "findings." Testimony to the contrary was either not heard or pointedly ignored.

Appearances by representatives of the Pharmaceutical Manufacturers Association and the AMA produced a mass of factual information and many helpful recommendations. All without much influence on the legislative result.

Based as it is on incorrect and misleading data, the Bill is largely composed of provisions for entities that are already established, for entities that are not needed, and for programs that are so fragile and useless that even the HEW Department is not interested.

Guest Editorials

The Doctor's Bill

I called some furniture movers once and this is what I was told. We charge from the time the truck leaves the office till it arrives back at the office. We don't work nights. We can move you on Saturday, but we charge time and a half for that. We don't work Sundays.

Well, I've worked many nights, and Saturdays, too. And I didn't charge time and a half, and I didn't charge from the time I left my home until I was back there. And I did work on Sundays, lots of them.

A record player that had been working before moving never worked again afterward, and my new carved-wood bookends were broken, but they said they were not responsible and not insured for things like that.

And I didn't hold my hand out for the money before I left; but they did.

If you think staying well is expensive, try moving, or eating, or driving, or clothing, or anything.—**Frank Cole, M.D., editor,** *The Nebraska Medical Journal,* **July 1974. Reprinted with permission.**

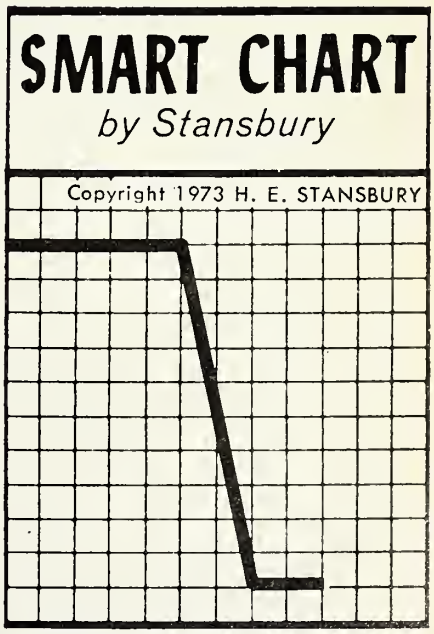
Editorial Notes . . .

The old absurdity that it is dangerous for athletes or others to drink water during strenuous physical activity has been officially laid to rest. The National Research Council has a Committee on Nutritional Misinformation, which has just issued a statement to the effect that dehydration is not only injudicious but possibly dangerous. Water intake to replace losses is recommended. It is also stressed that there is no evidence that man can adapt or be trained to tolerate water intake lower than his daily losses.

About 7,500 high school students worked in the 171 VA hospitals this summer, receiving an introduction to the health care fields. For example, the Medical University of South Carolina, Trident Technical College, and the VA hospital have enrolled 36 high school students in a 10-week course—mornings in the classrooms and afternoons at the hospital—in rotating assignments to nursing, medical library, laboratories, dietetics, psychology and other services.

The unauthorized retrieval of computerized medical records information will be one of the problems of the future. A standardized plan to set guidelines for the establishment and control of "ethical health data centers" has been developed by a group of professionals from medicine, law, religion and computer science in Buffalo. Standards for the training of those who store and retrieve confidential material are needed. About 90% of all psychiatric records and 40% of other medical or surgical records contain extra-sensitive information. New laws are needed. A high-grade set of morals and ethics is needed for the guidance of the operative personnel.

By definition, a child-resistant drug container must be unopenable by almost all children and also openable by most adults. The adults who have difficulty, due to arthritis or other disabilities, should request the pharmacist to give them easily opened containers. Meanwhile Owens-Illinois, one of the nation's largest producers of child-resistant containers, furnishes television stations with public service messages to popularize the use of the child-safe bottles whenever possible. ◄



"Remember when our attorney said it would cost nothing to talk things over?"



ABSTRACTS, BOOK REVIEWS

HARRISON'S PRINCIPLES OF INTERNAL MEDICINE—SEVENTH EDITION

Maxwell M. Wintrobe, Geo. W. Thorn, Raymond D. Adams, Eugene Braunwald, Kurt Isselbacher, Robert G. Petersdorf, editors, with the active collaboration of nigh seven-score co-authors, McGraw-Hill Book Co., NYC, 1974; in seven parts each further subdivided in from three to sixteen sections. Over 2,000 pages with innumerable illustrations plus exquisite color plates and extensive index; $29.50 for the one-volume set; $35.00 for the two-volume edition.

Each generation has teaching texts that tower over their contemporaries. Thus, at the turn of the century, "Osler's" was THE book. I'm looking now at the 17th edition put out by the Johns Hopkins Group and so numbered as a reminder that the last text bearing Osler's name was the 16th! Similarly, Cecil's text was changed to Cecil-Loeb and—later still—to Beeson and McDermott long after the original authors had departed this scene.

In this tradition, "HARRISON'S" is still so called, even if the original authors are no longer on the scene. The younger men taking over the never-ending task of revision and updating have performed a truly monumental task superbly! Good as the preceding editions have been (and you can see this reviewer's comments on the 6th edition in the Aug. 1973 *JISMA*), this one truly attains the heights. It is my personal opinion that this text will be the "Osler" of the last quarter of this 20th century. It will inevitably be used in medical schools; it will be on all hospital library shelves. Any doctor desiring to keep up with our ever-expanding knowledge, will keep it right over his working desk.

One can only marvel at the immense toil and dedication that went into the compilation of the monograph. May these young colleagues of ours have ahead of them long and productive lives! Of course, the binding, printing and paper are up to the highest standards of the profession. Congratulations all around!

ARNOLD LIEBERMAN, M.D.
New York City

THE HEART—THIRD EDITION

J. Willis Hurst with co-editors Logue, Schlant and Wenger, with some 140 individual chapter writers. McGraw-Hill Book Co., New York, 1974; $39.50; in nine parts each with countless sections and special articles; 1835 pages; numerous magnificent color plates besides photographs, graphs and diagrams.

Much of the reward one gets from doing book reviews consists in acquiring volumes of the magnificence and erudition that characterize this opulent tome! Just within the last several months, I've had come my way monographs—both new and updated editions—dealing with the multifaceted aspects of heart diseases: straight clinical material, research still in progress on the biochemical and physical bases of just what makes the heart tick (or stop), detailed anatomical structure as revealed by the tools acquired not too long ago or even just within the last few years—it makes me almost gasp with the joy of revelation! If I could *really* digest all this vast mass of knowledge, I would almost fancy myself a cardiologist of real expertise!

Having said all this, I can go ahead and only spot check the items that had particular appeal to me; your tastes will surely have a different slant! Thus (on pp. 240-242) there is an intriguing discussion of the W-P-W (Wolff-Parkinson-White) Syndrome. I liked the crisp, clear and concise presentation of the condition and the accompanying EKGs. Then (page 792 on) there is a beautiful analysis of the causation of rheumatic heart disease, its association with the Beta Hemolyticus Strep., the hereditary factors and the real possibility that we are overlooking a previously unsuspected viral link. As an addendum, I might add the unusual fact that in my own family there is rheumatic heart disease both on my and my spouse's side affecting the *females* only! I really ought to report this someplace. And: who can cavil the magnificent discussions on the cardiomyopathies? Reading from page 1334 on is instructive, no matter how well you *think* you are versed in the subject. And, from page 1652 on, there is an almost unique discussion of "Acute occlusion of a major splanchnic vessel." But why go on? Read it! You may like it all, too!

ARNOLD LIEBERMAN, M.D.
New York City

CORNEAL GRAFT FAILURE

Elsevier and Excerpta Medica, Edited by Ruth Porter and Julie Knight—Ciba Foundation Symposium #15 (new series), 1973; 363 pages; $21.00.

The usual couple dozen specialists contributed to the creation of this crisp and compact symposium. It is a curious fact —even if true—that ophthalmology is a specialty set apart, even though internists, such as I, look at fundi, pupils and the like. Therefore, I asked an eye specialist (whom I know well and for whose opinions I have the greatest respect) to scan this volume and give me his considered opinion. What follows is the gist of his remarks.

The texts of each paper have been highly edited and make for easy and enlightening reading. It is amazing but—just within the last five years—Ophthalmology has become divided into at least five sub-specialties! It is only the perusal of inexpensive and comprehensive monographs that enables the "man in the street" to learn of what is occurring in fields other than his own. Even the microsurgeon in ophthalmology has to run to keep up within his own field!

This present symposium deals in depth with immunology. The essential mechanisms of graft failure are explored, from selection of the donor eye and the patient to the surgical techniques and reasons for graft rejection. The presentation is accurate and up-to-date, even if the picture will have changed within the next five years.

The book cannot be recommended for *all* M.D.s but it does make very enjoyable reading for the ophthalmologist who wants to keep his knowledge current without having to strain unduly while doing so. Of course, the paper, printing and binding are up to the usual standards.

ARNOLD LIEBERMAN, M.D.
New York City

ANALYTIC AND EXPERIMENTAL EPIDEMIOLOGY OF CANCER

Edited by a group headed by Waro Nakahara, Proceedings of the 3d International Symposium of the Princess Takamatsu Cancer Research Fund, University Park Press, Baltimore; 1973; $32.50; 425 pages; numerous illustrations, discussions and a full list of references at end of each chapter.

This exquisitely made up monograph with the rather cumbersomely long title proceeds to actually deliver all it promises —and then some! Passing by the frontispiece showing in color

Continued

the princess with the participants surrounding her, we plunge directly into "Metabolic Epidemiology." The discussion on the etiology of Bladder Cancer sort of sets the tone for what follows: Why racial differences? What is role of diet? Vertical and horizontal pathways? Most lucid and thought provoking!

The "Immunological Epidemiology" of hepatocarcinogenesis: sober and challenging! The appearance of serumfetoprotein; the sequential changes through the *pre*neoplastic changes: all presented with great clarity (page 104). And then the discussion on Australia Antigen was masterly. I had reviewed (*JISMA,* Oct. 73) another item on this topic but a different approach is always refreshing. The rise of hepatoma *or* cirrhosis is spelled out beautifully.

One could discourse at length on the presentation of Marek's Disease, etc. but I'll merely call your attention to Professor Nakahara's closing remarks. On page 425 he summarizes and states, "The basket of classical cancer epidemiology has become too small and the contents are overflowing. It is time to reconstruct the basket. . . ." Amen!

ARNOLD LIEBERMAN, M.D.
New York City

DRUG RECEPTORS

Edited by H.P. Rang with a score of collaborators—Symposium held by the Biological Council on Drug Action, University Park Press, Baltimore, 1973; $24.50; 321 pages; profusely illustrated with electron photographs, tables and charts.

Specific labeling of the drug receptors was undertaken by the use of radioactive snake toxins (no less). Also, the electric organs of various fish such as the eel and the manta ray were unexpectedly rich sources of cholinergic receptors. So: the pharmacologists and the electro-physiologist—and other breeds of biochemists—met and had a field day applying their ideas to the drug receptor mechanisms. Allosteric enzyme regulation made giant strides forward: and then some!

It would be tedious to rehash such discussions as "Actions of Catecholamines on the Membrane Properties of Cells," "The Isolation and Molecular Properties of Receptor Proteolipids," "Studies on the Mode of Action of Cholinergic Agonists at the Molecular Level," and so on down the line.

Suffice to say that the presentations are on an excellent scientific level geared to the comprehension of any intelligent biochemist. I rather doubt that many practicing M.D.s would read the entire volume. However, the conclusions drawn are quite interesting (at least to me) and many of the summaries are well worth perusing.

As always, the paper, binding and printing are of high quality. I saw no typographical errors.

ARNOLD LIEBERMAN, M.D.
New York City

Abstracts from Various Literature, Prepared by AMA

AGING IN HIROSHIMA AND NAGASAKI ATOMIC BOMB SURVIVORS

R. E. Anderson et al. (Editorial Office, Atomic Bomb Casualty Commission, 5-2 Hijiyama Park, Hiroshima)
Am. J. Pathol. 75:1-12 (April) 1974.

Evaluation of 1,639 malignant tumors from 3,067 autopsies of members of the Extended Life Span Study Sample reveals that death occurs earlier in those persons most heavily irradiated ($\geq$100 rad) compared with those persons who were less exposed. This effect is particularly pronounced in the younger age categories and among women and is not attributable to a specific neoplasm. Assuming that a positive correlation exists between aging and the age-specific mortality of persons with neoplasms, this response is consistent with other observations that suggest the presence of accelerated or precocious aging in the most heavily irradiated group of survivors.

TREATMENT OF PAGET DISEASE OF BONE WITH PORCINE CALCITONIN

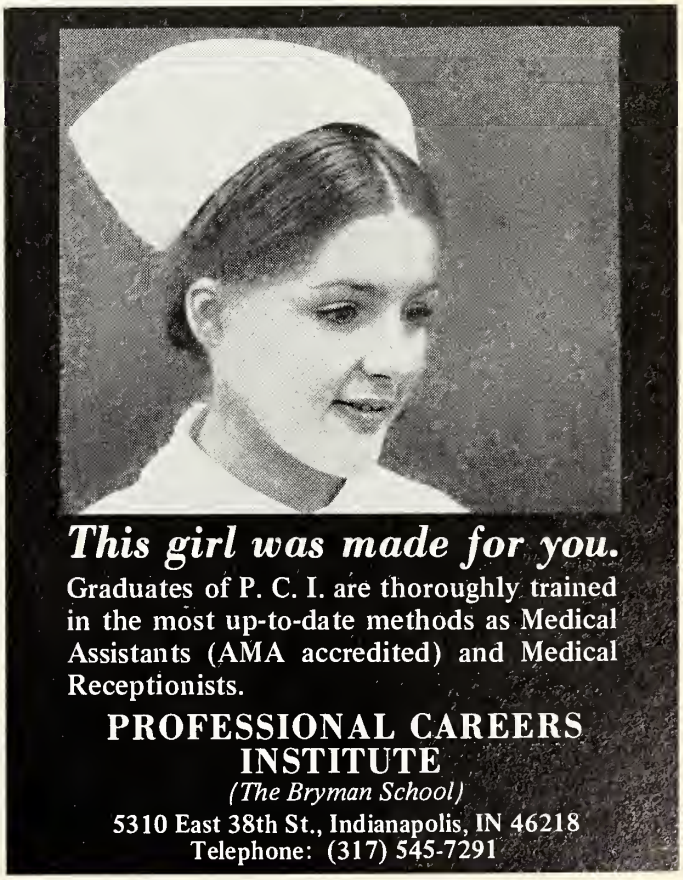
J. A. Eisman et al. (T. J. Martin, Austin Hosp., Heidelberg, Victoria, Australia)
Med. J. Aust. 1:564-568 (April 13) 1974.

Three patients with Paget disease of bone were treated for periods of 8 to 18 months with daily injections of porcine calcitonin. In all patients there were substantial decreases in the biochemical indexes of increased bone turnover. In two of the patients symptomatic relief of bone pain was obtained, and in one patient there was histological evidence of formation of normal bone after 12 months' treatment.

PROPRANOLOL VS SAPHENOUS VEIN GRAFT BYPASS FOR IMPENDING INFARCTION (PREINFARCTION SYNDROME)

A. M. Master (Mount Sinai School of Medicine, New York 10029) and H. L. Jaffe
Am. Heart J. 87:321-326 (March) 1974

The prognosis in impending infarction is good on a medical regime of bed rest and sedation. In a series of 18 patients treated with propranolol, the results were even better; there were no deaths or transmural infarction. Surgical intervention is not indicated in impending infarction and should be considered an experimental procedure at this time. ◄



The Woman's Auxiliary Reports to ISMA



Our guest writer this month is Mrs. George M. Reul, Kokomo, Indiana State Chairman for the American Medical Association Education and Research Foundation.

Beth Bowen

Mrs. Otis R. Bowen,

President

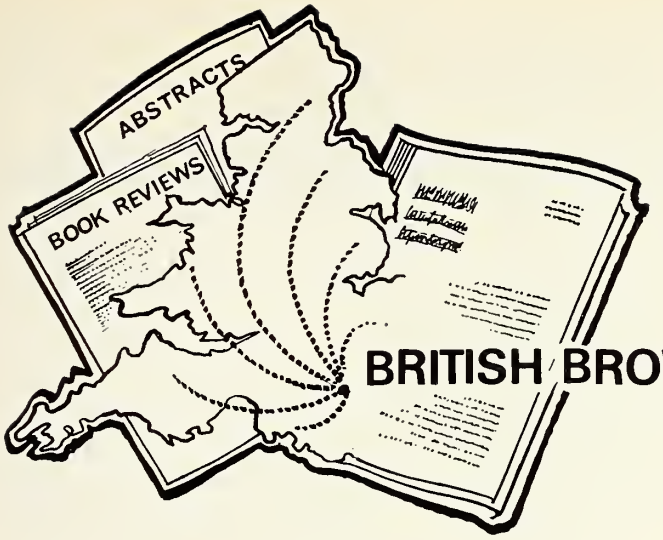
Dear Doctor:

This year I have the good fortune to be associated with one of our most worthwhile projects, the American Medical Association Education and Research Foundation Committee. Some of you may have been direct recipients of this program, while others have only heard of it. AMA-ERF works for medical education by providing unrestricted grants to medical schools and low interest loans to medical students, interns and residents. Every dollar given to the loan guarantee fund enables AMA-ERF to provide $12.50 to a needy student.

Last year AMA-ERF exceeded its stated goal of $1 million dollars in contributions nationwide. Indiana was particularly well represented. With your help, we received two merit awards. These beautiful engraved plates were given for the greatest increase over the previous year in total dollars contributed in the North Central Region, and for a per capita donation in excess of $20. One of these awards is proudly displayed in the ISMA building in Indianapolis. The other award was given to Mrs. Charlotte Bennett in appreciation of her tireless efforts as the 1973-74 Woman's Auxiliary State Chairman for AMA-ERF. In addition to the merit awards, Indiana received recognition as the fifth largest contributor to AMA-ERF in the nation.

"A million or more." That's the slogan for 1974-75. Federal grants continue to decrease and the value of the dollar shrinks as well. We are proud of our past achievements. With your continued support and generosity, we will achieve ever-improving medical education through AMA-ERF.

Sincerely,
(MRS.) SUSAN REUL
Indiana State Chairman AMA-ERF



BRITISH BROWSINGS

Duke H. Baker, M.D.
Indianapolis

The Mallory-Weiss Syndrome

The Mallory-Weiss syndrome, first described in 1929, was initially thought to be a rare cause of upper gastrointestinal bleeding. More recently, however, the possibility has been raised that the syndrome might not be so uncommon.

D.J.B. St. John and his colleagues at Monash University in Melbourne, Australia, recently presented their experience with the investigation of 121 cases of major upper gastrointestinal bleeding. Endoscopy with a forward-viewing fiberoptic endoscope was performed as the initial investigation on most of these patients admitted for bleeding, usually within eight hours of the time of admission to the hospital.

The policy of immediate investigation of patients with haematemesis or melaena or both led to the diagnosis of the Mallory-Weiss syndrome in 16 out of the 121 patients admitted to a combined medical-surgical unit over a period of three and a half years.

The criterion for diagnosis of Mallory-Weiss Syndrome was the finding of single or multiple longitudinal mucosal tears at, or immediately below, the gastroesophageal junction, irrespective of the presence or absence of a history of vomiting, before haematemesis. In 12 of the 16 patients with the syndrome, a linear mucosal tear typical of the Mallory-Weiss lesion was identified at oesophagogastroscopy performed as the first investigation in the hospital. A typical history suggestive of the diagnosis was obtainable in only 9 of the 16 patients, though recent alcohol intake was high in another four. All 16 patients survived the episode without complication.

Establishment of the diagnosis by oesophagogastroscopy was of special benefit when surgery was needed for control of continuing blood loss, but it also simplified the subsequent medical management of those patients in whom bleeding stopped spontaneously.

The incidence of 13.2% in this series suggests that the Mallory-Weiss syndrome may be a relatively common cause of upper gastrointestinal bleeding.[1]

Problems of Administering Drugs by Continuous Infusion

In the introduction to their article in the March 2, 1974, issue of the *British Medical Journal*, P. Brodlie and co-workers point out that over the last decade the practice of administering drugs by continuous intravenous infusion has become more common, particularly in surgical units. This route of drug administration has many potential hazards and special precautions should be taken for therapy to be safe and effective. The main dangers are associated with incompatibility between the drug added and components of the infusion fluid, possible decomposition over the time of administration, and any bacterial or fungal contamination inadvertently introduced when the admixture is prepared.

To investigate the problems of administering drugs by continuous infusion, a multidisciplinary team of medical, nursing and pharmaceutical staff was assembled at the University of Dundee in Scotland. A study of how often drugs were administered by continuous intravenous infusion to patients occupying 110 surgical and 50 medical beds showed that an average of 48 drug additions were made to intravenous fluids each week. For medical beds only one drug was added on each occasion, whereas for the surgical beds 15% of the additives contained two or more drugs and 15% were of drugs incompatible either with each other or with the infusion fluid. Antibiotics were the most common additives, apart from potassium chloride.

As a result of the survey, an educational programme was begun to alert nursing and medical staff to the problems associated with giving drugs by continuous intravenous infusion. The first part introduced an incompatibility chart which provides a continuous form of educa-

tion as the information is always available at the time the prescription is written. The second part consisted of symposia covering not only incompatibilities and contamination occurring when drugs are administered by continuous intravenous infusion but also the difficulty of obtaining a therapeutic blood level of the drug when it is run in at an erratic rate from a dilute solution.

After this programme a second survey showed only 18 additives per week had been given to patients occupying the same 160 beds and none of these were incompatible mixtures.[2]

Saphenous Nerve Injury Caused by Stripping of the Long Saphenous Vein

Recently a study was carried out at St. Thomas's Hospital, London, designed to determine the incidence of sensory loss on the medial aspect of the lower leg following stripping of the long saphenous vein, and to ascertain whether the direction in which the vein is stripped affects the incidence and area of postoperative sensory deficit. Sensory impairment in the cutaneous distribution of the saphenous nerve was measured in 30 patients after bilateral stripping of the long saphenous vein. The vein was stripped upwards in one leg and downwards in the other.

Three months after operation a significantly greater incidence of sensory loss was found in those legs in which the vein was stripped upwards (13 out of 26) compared with those which had been stripped downwards (6 out of 26) ($P<0.05$). The area of sensory loss in the 13 patients in whom the vein had been stripped upwards (mean 39 cm^2; range 1-120 cm^2) was similar to the area lost in those stripped downwards (mean 36.5 cm^2; range 2.5-92 cm^2) with no statistically significant difference.

Based on this study, the authors suggest that the long saphenous vein should be stripped from above downwards to lessen trauma to the saphenous nerve below the knee.[3]

REFERENCES

1. St. John, D.J.B., Masterton, J.P., Yeomans, N.D., Dudley, H.A.F.: The Mallory-Weiss Syndrome, *Brit. Med. J.* 1:140-143, 1974.
2. Brodlie, P., Henney, C., Wood, A.J.J.: Problems of Administering Drugs by Continuous Infusion, *Brit. Med. J.* 1:383-385, 1974.
3. Cox, S.J., Wellwood, J.M., Martin, A.: Saphenous Nerve Injury Caused by Stripping of the Long Saphenous Vein, *Brit. Med. J.* 1:415-417, 1974. ◄



FUTURE MEETINGS, SEMINARS, COURSES

College of Cardiology to Present Series of Programs in Indiana

The American College of Cardiology will present the following continuing education programs in Indiana during the academic year September 1974 through August 1975:

Myocardial Ischemia: A Clinical Frontier
Oct. 7-9, 1974, Indiana University Medical Center, Indianapolis
Directors: Suzanne B. Knoebel, M.D., and Borys Surawicz, M.D.
Core Curriculum: Phonocardiography and Pulse Recording — Workshop
Oct. 31-Nov. 2, 1974, Methodist Hospital Graduate Medical Center, Indianapoils
Director: Morton E. Tavel, M.D.
Electrocardiographic Interpretation of Arrhythmias: A Physiological Approach
Mar. 24-26, 1975, Indianapolis
Director: Charles Fisch, M.D.

Address the College at 9650 Rockville Pike, Bethesda, Md. 20014, for full details.

Announce Course on Thyroid Disease

The Medical College of Wisconsin will sponsor a postgraduate course on Thyroid Disease on October 11 and 12. Subject matter will deal with the most recent advances in diagnosis and treatment. Full information may be obtained by writing Anne T. Finnegan, 561 N. 15th St., Milwaukee 53233.

Leukemia-Lymphomas Conference Topic

"Updating Our Knowledge and Treatment of Leukemia-Lymphomas" is the subject of a program to be conducted by the Florida Division of the American Cancer Society at the Host Airport Hotel at Tampa International Airport on November 22. Get the whole story by writing the Florida Division, ACS, 1001 S. MacDill Ave., Tampa 33609.

Pulmonary Function Course at Tulane

The 11th Annual Postgraduate Pulmonary Function in Health and Disease Course will be held at Tulane University Medical School Auditorium December 9 to 12. Tuition is $135. Write Course Coordinator, 333 St. Charles Ave., Suite 1504, New Orleans 70130.

Pediatric Gastroenterology Conference Scheduled at Indianapolis in December

A Conference on Pediatric Gastroenterology will be held in Indianapolis at the Stouffer's Indianapolis Inn on December 11 and 12, 1974. The presentations will include: Bilirubin Metabolism—Dr. John Johnson (Palo Alto); Neonatal Jaundice—Dr. J. Rainer Poley (Oklahoma City); Obstructive Liver Disease in Infants—Dr. Daniel M. Hays (Los Angeles); Viral Hepatitis—Dr. Saul Krugman (New York); Chronic Liver Disease in Children—Dr. Reuben S. Dubois (Denver); Liver Failure—Dr. Charles Trey (Boston); Hepatic Transplantation in Children—Dr. Thomas E. Starzl (Denver); Diarrhea—Dr. J. R. Hamilton (Toronto); Malabsorption—Dr. Marvin E. Ament (Los Angeles); Microbiology of the GI Tract—Dr. John D. Nelson (Dallas); Ulcerative Colitis—Dr. William M. Michener (Cleveland); Crohn's Disease—Dr. Joseph F. Fitzgerald (Indianapolis); and the banquet speaker Dr. Thomas E. Starzl—Ethical Considerations of Human Transplantation.

For further information concerning the conference contact Dr. Joseph F. Fitzgerald, Indiana University Medical Center, 1100 West Michigan Street, Indianapolis 46202.

Variety of Courses Scheduled by Indiana University Medical School

"Common Hematologic Disorders—A Review for the Practicing Physician" October 17, 1974
A review of the disorders that affect blood cell formation and life span. The attendees should come away with a better knowledge of how they can manage patients in their own offices and hospitals, and a better identification of which patients require the facilities and expertise of large medical centers.
"Otolaryngology Workshop for the Family Practitioner" October 30, 1974
The objectives of this workshop are to present practical aspects of otolaryngology as it is practiced by the family physician. Emphasis will be placed on actual techniques of diagnostic and treatment procedures for problems commonly encountered by the family practitioner. As much as possible, the course will be problem-oriented, with the hope that the registrant can readily apply material presented to his own practice.

"Office Orthopaedics"
November 6, 1974
Each year the Orthopaedic Department identifies several areas of concern to practicing primary care physicians and discusses or demonstrates them in detail.

"Venereal Diseases",
November 13, 1974
This course will be conducted at the Northwest Center for Medical Education.

"Practical Obstetrics and Gynecology"
November 20, 1974
Co-sponsored by Indiana Academy of Family Physicians and Indiana University School of Medicine

This course is directed to those physicians taking care of Ob-Gyn patients. Selected topics in Endocrinology Reproductive System, recent advances in office diagnostic technique, and problems with the fetus will be discussed.

For further information contact: Division of Postgraduate Medical Education, Indiana University School of Medicine, 1100 W. Michigan St., Indianapolis 46202

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We're a company that thrives on vigorous competition. In fact, it's our gaming spirit that has helped make us Indiana's fastest growing clinical laboratory.

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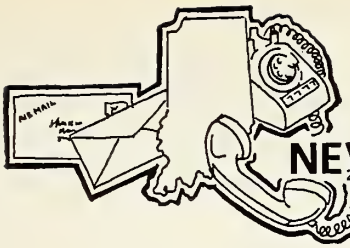
So, you'll not see us out hawking a $2.00 Pap . . . or a $3.00 T4 . . . or a $6.75 Culture & Sensitivity.

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NEWS NOTES

Statement of Joint Committee on Health Problems in Education

Dispensing Medications in School

The following statement on dispensing medications in school was passed by the Joint Committee in September 1973:

School personnel are often faced with the responsibility of dispensing medication at school. A student may have an illness which requires medication for relief or cure that does not prevent his attending school. If possible, such medication should be given by the parents and taken at home. However, if the student needs to take his medication during school hours in order to assume full participation in the school program, dispensing the medication may become the responsibility of the school.

Guidelines for the benefit of those involved are needed, particularly in view of widespread concern over the abuse of drugs. School administrators should meet with school health service professionals and the local medical society, in order to work out a mutually acceptable plan for dispensing medication in schools. The final plan should be made known to parents, students and other members of the community.

The following guidelines are suggested:

1. The school principal should appoint one responsibile person—e.g., the school nurse, or other, to supervise the storing and dispensing of medications.
2. The medication should be brought to the school by the parent of the student. The student should not carry the medication with him or administer it to himself.
3. For legal purposes, written permission should be obtained for dispensing drugs to a student from both his parents and his physician.
4. The person in charge of dispensing drugs should keep them in a locked place that is not easily accessible to either students or others in the building.
5. Each student's medication should have affixed a prescription label including his name, the name of the drug, and directions concerning dosage. Instructions about the duration of the medication period should be included.
6. The school nurse should give at least the first dose of any medication. She should explain to the child and his teachers all possible side effects of the medication.

Named Central State Hospital Head

Dr. George T. Teaboldt, Logansport, has been named superintendent of Central State Hospital, Indianapolis. He has been acting superintendent since May. A psychiatrist, Dr. Teaboldt is a 1957 graduate of the Indiana University School of Medicine. Until last May he was clinical director of Logansport State Hospital.

Dr. Beaver Honored by St. Joseph's

Dr. E. Raymond Beaver, Rensselaer, was one of the recipients of the Schuyler Lee Robinson College Community Award at ceremonies held on the Saint Joseph's College campus on July 10. The award is presented each year to the persons or group of people who have contributed most significantly to the life of the college during the past year. In practice in Rensselaer since 1946, Dr. Beaver is currently chief of staff of Jasper County Hospital and president of the County Medical Society.

Hospital Medical Staffs Elect

Officers of the medical staff and department heads of Bedford Medical Center have been announced. Named chief of staff is **Dr. Peter Livingston;** treasurer and chief of staff-elect is **Dr. Medhat Girgis.**

Chiefs of the various services at the Medical Center are **Dr. Guy H. Waldo,** internal medicine; **Dr. Donal Kaderabek,** general surgery; **Dr. George Sorrells,** pediatrics; **Dr. James Mount,** obstetrics and gynecology; **Dr. Abdel W. Sami,** pathology; **Dr. Raul Gonzalez,** radiology; **Dr. Livingston,** urology; **Dr. Eugenio Tan,** anesthesiology; **Dr. Richard Huber,** general practice, and Dr. Prasoon Samaddar, otolaryngology.

Dr. John Kelly was recently elected president of the medical staff of Welborn Baptist Hospital, Evansville, for the coming year. **Dr. John Lawler** was chosen president-elect, and **Dr. Dale Lehman,** secretary-treasurer. **Drs. Gilbert Himebaugh, Alfred Lessure** and **Jack Williams** were elected to the Executive Committee, along with **Dr. Gregg Sheehan,** immediate past president.

The following will serve as officers of the medical staff of the Orange County Hospital, Paoli: President, **Dr. Ivan A. Clark;** vice president, **Dr. Charles X. McCalla,** and secretary, **Dr. John K. Spears.**

Medical Assistant Program Accredited

The Indiana Vocational Technical Colleges at Kokomo and Lafayette have been granted accreditation of the medical assisting program by the Council of Medical Education of the AMA, in collaboration with the American Association of Medical Assistants. The program provides a basic knowledge of anatomy, physiology, medical terminology, medical law and ethics, human relations, bookkeeping, insurance, administrative, laboratory and clinical procedures.

Dr. Miller's Chapter Reprinted

Dr. Roscoe E. Miller, Indianapolis, is the author of a chapter, "The technical approach to the acute abdomen," in *The Acute Abdomen,* edited by Benjamin Felson. The chapter is reprinted from *Seminars in Roentgenology,* vol. 8, no. 3, 1973.



VICE-PRESIDENT OF THE UNITED STATES Gerald Ford exchanged ideas with Joe Dukes, M.D. (center), president, Indiana State Medical Association, and (right) Indiana's Governor Otis R. Bowen, M.D., at the 123rd Annual Convention of the American Medical Association in Chicago in June.

CHAMPUS Program Changes Announced

Cost-Sharing

In the past CHAMPUS permitted certain outpatient claims to be processed as inpatient care.

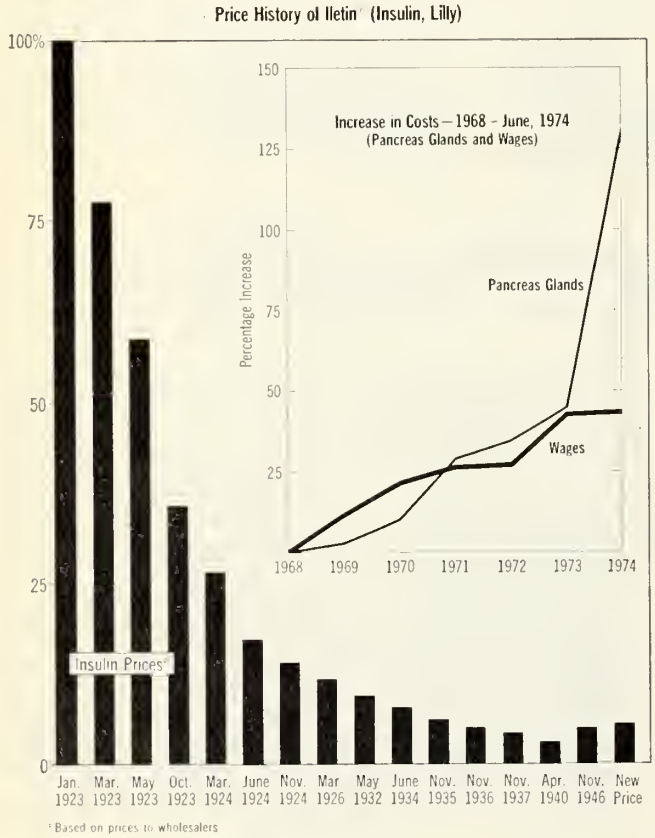
Effective 1 August 1974, all claims for outpatient treatment except for maternity and certain types of treatment in Ambulatory Surgical Centers of similar facilities, will be cost-shared under the outpatient cost-sharing rules.

Additional information concerning maternity care and treatment in Ambulatory Surgical Centers will be forthcoming.

Psychiatry

Effective 1 July 1974 CHAMPUS will limit cost-sharing coverage of psychotherapeutic/psychiatric care for a mental or emotional disorder to 120 days in an inpatient facility.

CHAMPUS coverage of outpatient visits for psychotherapeutic/psychiatric care will be limited to 40 visits per fiscal year (1 July through 30 June). Patients who presently have CHAMPUS "extended-hospitalization" approval for periods extending beyond 1 July 1974, will not be subject to this new limitation until their authorized period terminates. However, the 120-day hospitalization limitation will apply concurrently with any previously approved "extended-hospitalization" on and after 1 July 1974. For example, if extended care for a mental or emotional disorder has been authorized on CHAMPUS Form 127 through 31 August 1974, then up to 58 days of inpatient care and 40 outpatient visits are available to the patient until 1 July 1975.



ELI LILLY AND COMPANY has just announced a 10% increase in price for standard insulin products—the first price increase for insulin in 28 years. The chart above illustrates the history of insulin prices since 1923 and the increases in basic costs since 1968.

Four Honored by Pharmacists

Four physicians with 40 years of practicing medicine in Muncie were honored recently by the Delaware County Pharmaceutical Association. **Drs. T. R. Hayes and Lall Montgomery** received plaques from Ray Crick, president of the pharmacists, in ceremonies at the Delaware Country Club. Also cited but not present were **Drs. J. R. Hurley and M. G. Schulhof.**

Mental Health Program Grants Made

Congressman William Hudnut has announced two HEW grants for mental health programs. One for $230,091 goes to the Marion County General Hospital for the Midtown Community Mental Health Center Children's Program. This is the first-year grant on a proposed eight-year program. The other grant is for $67,381 for the first year of a 3-year psychiatric follow-up project which will be conducted at Carter Memorial Hospital. The fund will provide for an evaluation of hospital treatment as well as follow up on outpatient treatment.

Radiologic Technologist Appointed

Lawrence D. Myers, radiologic technologist, who was formerly on the Radiology Department staffs of Winona Hospital, Indianapolis, St. Anthony's Hospital, Terre Haute, and at Indiana University Medical Center, has been appointed midwest representative of the Medical and Photographic Products Division of LogEtronics of Springfield, Va. Working out of Indianapolis, he will be responsible for application of the company's LogEscan®Radiograph Minification Systems.

50 Years in Bluffton Celebrated

The 50th anniversary of **Dr. Truman Caylor's** start in the medical field in Bluffton was celebrated on June 28 with ceremonies at the Caylor-Nickel Clinic.

Coble Legion Post Elects

Dr. Byron L. Steger, Indianapolis, was recently elected commander of the Paul Coble Post No. 26 of the American Legion.

Other physicians serving as officers of the Post are **Dr. Robert L. Rudesill,** second vice commander; **Dr. Harlan H. Tyner,** adjutant, and **Dr. Richard A. Brickley,** sergeant-at-arms.

Dr. Lloyd Smith Goes to Illinois

Dr. Lloyd H. Smith, North Manchester, who founded the Manchester Clinic 16 years ago, has taken a position on the medical staff at Southern Illinois University at Carbondale.

Speaks at Women's Worry Clinic

Dr. Gustaf W. Erickson, a South Bend pediatrician, will be one of the featured speakers at the second annual Women's Worry Clinic to be held at Warsaw by the Kosciusko County Mental Health Association. His topic will be "Koping with Kids" for those with children of preschool and elementary school age.

Voluntary Sterilization Subject Of Recent Public Affairs Pamphlet

Public Affairs Pamphlet No. 507 is entitled "Voluntary Sterilization." It is written for the general public. It explores the changing attitudes in regard to sterilization and considers some of the practical and psychological aspects of it. The price is 35 cents. Write to 381 Park Avenue South, New York City 10016.

Retire from Active Practice

Dr. Jesse C. Ambrose, Noblesville, retired recently after 39 years of active general practice.

Dr. Robert M. Dearmin, Indianapolis otolaryngologist, retired this summer, 50 years after his graduation from the Indiana University School of Medicine.

Dr. Emil H. Dowell brought nearly 48 years of medical practice in Rockville and Parke County to a close on June 28 when he retired.

Order of St. Luke Meets

The International Order of St. Luke the Physician held its first regional conference at Christ Church Episcopal Cathedral, Indianapolis, recently. One feature of the two-day session was a program in which a panel of physicians answered questions on various aspects of spiritual healing. Members included: Dr. William Murray, state commissioner for mental health; **Dr. Frank Lloyd,** vice-president of medical research, Methodist Hospital, and **Dr. Ivan F. Bennett,** clinical investigation division of Eli Lilly & Co.

Dalkon Shield Sales Suspended

Sale of the Dalkon Shield will be suspended by A. H. Robins Company pending an FDA study to determine if the device is less safe than other IUDs. The company advised FDA of clinical reports and sent letters to more than 120,000 doctors. Neither the company nor FDA has advised removal of the device. FDA will seek safety and effectiveness information on all IUDs.

Retires as County Health Commissioner

Appreciation to **Dr. Hubert T. Goodman, Terre Haute,** Vigo County Health Commissioner, for his service to the community, was given in the form of a special plaque presented recently on the occasion of his retirement from that office.

PMA's Consumer Advertising Best

The Pharmaceutical Manufacturers Association consumer advertising campaign was the unanimous first choice in the Saturday Review/World's 1974 awards competition for advertising strictly in the public interest. The winning series on health hints covered high blood pressure, the general value of pharmacists, industry's expensive research, and the major challenges still facing research. PMA's medical advertising program for the profession likewise has enjoyed huge success.

Progress in Cancer Highlighted

An entirely remodeld exhibit "The Hopeful Side of Cancer" opened this summer at the Chicago Museum of Science and Industry. The exhibit is presented by the Illinois Division of the American Cancer Society. It emphasizes early diagnosis and highlights the advances in treatment possibilities. The Museum and the exhibit is free of charge. Free parking is plentiful.

Doctor Speaks to Historic Group

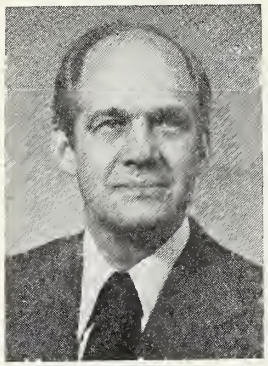
Dr. James R. Lewis, Richmond, spoke on "Four Generations of Hoosier Doctors" before the Hagerstown Historical Association recently. In April, Dr. Lewis spoke at the Indiana History Workshop at Turkey Run State Park.

Dr. Dye Reelected School Board Head

Dr. William E. Dye, Oakland City, has been reelected president of the board of school trustees of the East Gibson School Corporation. He was first elected president in 1965 and has served continuously in that office ever since.

Dr. Wilhelmus Wins College's Highest Accolade

Lockyear College, Evansville, has awarded Gilbert M. Wilhelmus, M.D., president-elect of the Indiana State Medical Association, its Distinguished Service Award.



Dr. Wilhelmus received the award at the annual commencement of Lockyear on June 6, 1974. It is awarded to only one person, annually, by the college.

Considered the highest honor that the college may bestow, it is given to an individual who has contributed philanthropically to his profession, community and education and as an expression of appreciation by the college to the individual for non-pecuniary endeavors beyond the scope of his normal duties and responsibilities.

Doctor Wilhelmus's award reads:

"In recognition of his professional efforts in behalf of this College, Community, State and Country—1974."

Communities Get NHSC Physicians

Three National Health Service Corps physicians recently began practice in Indianapolis. Dr. Mark Jabbusch, family practice, is at the Peoples Health Center. Dr. Themen Danielson, Jr., family practice, is at the Citizen's Ambulatory Care Center. Dr. Eugene M Kenigsberg, pediatrics, splits his time equally between the two centers. It is expected that the three physicians will practice in Indianapolis for the duration of their two-year tours with the NHSC.

Two NHSC physicians began practice in Liberty on July 1. They are Drs. James Hinchen and Louis E. Schroder.

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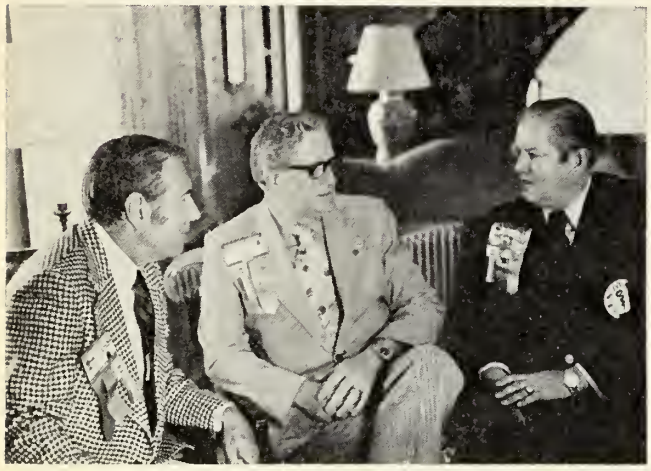
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CONFERRING at the June meeting of the American Medical Association in Chicago are (left to right) Malcolm C. Todd, M.D., AMA president; Indiana Governor Otis R. Bowen, M.D., and Joe Dukes, M.D., president, Indiana State Medical Association.

Dr. Robert Berke Certified

Dr. Robert D. Berke, South Bend, has been certified as a diplomate of the American Board of Allergy and Immunology. The board is a joint unit of the American Board of Internal Medicine and the American Board of Pediatrics.

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ARNOLD H. KAMBLY, M.D.
Psychiatrist-Director

Speaks on Women's Sports Programs

Dr. Jerard G. Ruff, Bloomington, was the featured speaker at a recent conference on the Indiana University campus sponsored by the School of Health, Physical Education and Recreation Alumni Association. He spoke on women's sports programs, touching on the urgent need to extend equal opportunities to women at all levels of athletic competition.

Named Culver Medical Director

Dr. Donald F. MacLeod, West Lafayette, has been appointed by Culver Educational Foundation as medical director of Culver Military Academy and the Culver Academy for Girls. He has been associated with the Purdue Health Center and Purdue University Hospital since 1956.

Schedule for Upcoming NCME Programs

Here ore the playing dotes ond upcoming programs to be distributed by The Network for Continuing Medicol Educotion (NCME):

Sept. 9-22

RENAL BIOPSY: WHEN WILL IT HELP THE CHILD? with Shone Roy, III, M.D., Pediotric Nephrologist ond Associate Professor of Pediatrics, University of Tennessee School of Medicine, Memphis.

THE VAGINA AND SEXUAL DYSFUNCTION, with Philip A. Sarrel, M.D., Associate Professor of Obstetrics ond Gynecology, Yole University Medical School, ond Mrs. Lorno Sorrel, Co-Director, Humon Sexuolity Progrom, Yole Student Mentol Hygiene Department, New Hoven, Conn.

THE NATIONAL ANTIBIOTIC THERAPY TEST: FIRST RESULTS, with Edmund D. Pellegrino, M.D., Choncellor of the Medical Units, University of Tennessee and member of the NCME Medical Advisory Committee; Alon L. Goldberg, M.D., fomily physician from the Bronx and member of the NCME Medicol Advisory Committee, ond Harold C. Neu, M.D., Head, Infectious Diseases, Columbio University College of Physicions ond Surgeons, New York.

Sept. 23-Oct. 6

EARLY PROSTHETIC FITTING FOR CONGENITAL DEFECTS, with Chorles H. Epps, Jr., M.D., Department of Orthopedics, Howard University School of Medicine, Washington, D.C., and Chief, Juvenile Amputee Clinic, D.C. General Hospitol.

THERAPEUTIC ANESTHESIA FOR LOCALIZED PAIN, with William C. North, M.D., Professor ond Chairman, Department of Anesthesiology, University of Tennessee School of Medicine, Memphis.

SENATOR BENNETT MEETS THE PROFESSIONALS, with Senotor Wallace F. Bennett, sponsor of PSRO legislotion; Robert B. Hunter, M.D., AMA Board of Trustees ond Chairmon AMA Advisory Council on PSRO; Jomes L. Henry, M.D., President, Ohio Stote Medicol Association; ond J. Lewis Schricker, Jr., M.D., President, Utah State Medicol Association.

(Progrom scheduling subject to chonge)

For more information obout NCME, write The Network for Continuing Medical Education, 15 Columbus Circle, New York, N.Y. 10023.

County, District News

Second District

At June 13 meeting the following were elected: President, Dr. Jack L. Shanklin, Vincennes; secretary-treasurer, Dr. J. S. Brown, Carlisle; Dr. Joe Dukes, Dugger, was reelected to the Blue Shield Board of Directors, and Dr. Edgar R. Cantwell, Vincennes, was elected alternate trustee.

Fourth District

The annual meeting of the Fourth Trustee District was held on June 12, and the following were elected: President, Dr. A. A. Daftary, Batesville; president-elect, Dr. Robert P. Acher, Greensburg; secretary-treasurer, Dr. Lanny Copeland, Osgood; trustee, Dr. Howard C. Jackson (reelected).

The after-dinner speaker at the meeting at the Seymour Country Club was Dr. Jose Garcia Oller, New Orleans neurosurgeon and president of the Council of Medical Staffs. His topic was PSRO.

Ripley County will be host to the 1975 meeting.

Ninth District

At the Ninth Trustee District's annual meeting on June 13 at the Frankfort Country Club, Dr. Max N. Hoffman, Covington, was reelected alternate trustee.

Jasper County will be host to the 1975 meeting, which will be held at Rensselaer.

Clark

A public forum on Professional Standards Review Organizations was held on June 7 at the Jeffersonville High School Arena under the sponorship of the Clark County Medical Society and the Southeast Indiana Comprehensive Health Planning Council.

The acting director of the Division of Quality and Standards, HEW, Chicago, presented the government's views on PSRO, and Dr. David G. Crane, Bloomington, discussed how PSRO will affect the patient.

Following these two presentations, a panel discussion was held, with Ninth District Congressman Lee Hamilton serving as one of the panel members.

Grant

Dr. Robert Doll, Pittsburgh, Pa., was the speaker at the May meeting of the Grant County Medical Society. His subject was hypertension.

Dr. James A. Harshman, Kokomo, 11th District Trustee, was present and spoke on PSRO and the PSRO support center, the Tel-Med program, and Rogers Bill 13995.

About 50 members were present.

Madison

A $10,000 scholarship fund to benefit Anderson College nursing students from the Madison County area has been established by the Madison County Medical Society and Lilly Endowment, Inc., Indianapolis. Used to provide tuition and nursing equipment aid, the new scholarship will be made available to area students on the basis of need and aptitude.

Anderson College's two-year associate of science degree program in nursing will admit its second class of students with start of fall semester classes.

Officers have recently been elected by a number of county medical societies, as follows:

Cass

Dr. Francis W. Parker, Jr., is the new president of the society, not Dr. Camille Parker, as stated in the May issue. Dr. Joseph S. Bean is secretary.

Clark

Dr. George H. Rudwell, president; Dr. Thomas Neathamer, vice-president; Dr. Roy Fultz, secretary-treasurer; Dr. David Jones, delegate, and Dr. William L. Voskuhl, alternate delegate. Drs. Rudwell, Neathamer and Fultz are all of Jeffersonville, while Drs. Jones and Voskuhl are of Charlestown.

Clay

Dr. Robert C. Oehler, president; Dr. Everett Conrad, secretary-treasurer; Dr. Charles E. Moon, delegate, and Dr. Robert M. Maurer, alternate delegate. All are of Brazil.

Dearborn-Ohio

President, Dr. Ivan Lindgren, Aurora; vice-president, Dr. R. H. Dizon, Lawrenceberg; secretary-treasurer, Dr. Leslie M. Baker, Aurora.

Decatur

Dr. Robert Acher, president; Dr. Alfredo Q. Paje, secretary; Dr. Arnold Duncanes, secretary-treasurer, with Drs. Acher and Paje serving as delegate and alternate.

Fayette-Franklin

Dr. Joseph L. Steinem, Connersville, has been elected president, while Abou Mazdai, also of Connersville, continues as secretary.

Huntington

Dr. Richard G. Blair has been elected president and Dr. Arthur N. Larson, secretary; both are of Huntington.

Jackson-Jennings

Dr. Joel L. McGill, Brownstown, has been elected secretary; Dr. John C. Linson, Seymour, is serving as president.

Knox

President, Dr. Daniel J. Combs; vice-president, Frederick H. Buehl; secretary, Donald L. Snider, and treasurer, Rudsen M. Bueser. All are of Vincennes.

Owen-Monroe

Dr. Robert D. Robinson, Jr., president; Dr. Larry D. Ratts, vice-president; Dr. Kermit Hibner, secretary, and Dr. James Greenlee, treasurer. Dr. Paul W. Holtzman was elected to a three-year term on the executive committee, and Drs. William Anderson, Roger Robison and Robert Rose were named delegates. Their alternates are Drs. Charles McClary, Charles McKeen and Rodger Buck.

Drs. Rose and Buck are of Spencer; the others are of Bloomington.

Ripley

Dr. Manuel G. Garcia, Batesville, will serve as president and as delegate, with Dr. Jordi Gaton of Milan serving as secretary and Dr. William J. Warn as alternate delegate.

Shelby

Dr. E. T. Banguis, Shelbyville, is the new secretary; Dr. Robert Inlow continues as president.

Deaths

Arthur Goldstone, M.D.

Dr. Arthur Goldstone, Gary, was killed in a plane crash near Aspen, Colo. March 24, in which his wife, two sons and a daughter also were killed. He was 39.

A graduate of the University of Illinois College of Medicine in 1960, Dr. Goldstone came to Gary following an internship at Cook County Hospital, Chicago.

He served in the Air Force in 1962 and 1963.

Dr. Goldstone had served as a delegate from the Lake County Medical Society to the Indiana State Medical Association and was a member of the American Medical Association.

Walter E. Kruse, M.D.

Dr. Walter E. Kruse, 78, Fort Wayne, died July 20 in Lutheran Hospital.

A graduate of the St. Louis University Medical School in 1923, Dr. Kruse interned at St. John's Hospital.

He served as Allen County coroner from 1937 to 1940 and was Fort Wayne health commissioner from 1950 to 1954. He was a member of the board of the Irene Byron Hospital, now Byron Health Center, for a few years after appointment in 1967.

A former president of the Allen County Medical Society, Dr. Kruse was a Senior Member of the Indiana State Medical Association and the American Medical Association and became a member of the ISMA Fifty Year Club in 1973.

Hugh K. Navin, M.D.

Dr. Hugh K. Navin, Fortville, died July 13 in Community Hospital, Indianapolis. He was 72.

He began his practice at Fortville on July 4, 1935, having graduated from the Indiana University School of Medicine in 1934 and having interned at the Indianapolis City Hospital. He remained in active practice until the time of his death.

During World War II Dr. Navin was a physician for the Selective Service in Hancock County. He was a member of the medical staff at Methodist Hospital, Indianapolis and was a member of the Hancock County Medical Society and the American Medical Association. In 1973 he became a Senior Member of the Indiana State Medical Association.

Kenneth R. Ockermann, M.D.

Dr. Kenneth Russell Ockermann, Rensselaer, dicd July 9 at Milton, W. Va. He was 59.

Following graduation from the University of Louisville School of Medicine in 1941, he entered the Army Medical Corps in 1942 and served until 1945. As a Captain in the Medical Corps, he was awarded the Purple Heart, Bronze Star and the Combat Medical Badge.

After the war, he first set up civilian medical practice in Kimball, W.Va., but relocated in DeMotte in 1948. In 1953 he moved his practice to Rensselaer where he had served as county health officer for a number of years.

Dr. Ockermann was a member of the American Medical Association and served as Jasper County Medical Society delegate to the ISMA for many years. He also served as county society secretary and, in 1969, as president. He was a diplomate of the American Board of Family Practice.

Warren H. Pike, Jr., M.D.

Dr. Warren H. Pike, Jr., Hobart, died at the Hobart Mercy Hospital June 21. He was 55.

He was graduated from the University of Maryland Medical School in 1945 and interned at Presbyterian Hospital, Chicago, becoming licensed in Indiana in 1948.

During World War II he served in Japan with the rank of Captain in the Army Medical Corps.

He served as a Deputy Lake County Coroner from 1948 to 1964 and also served as the doctor for the Hobart schools and athletic department.

Dr. Pike was a member of the Lake County Medical Society and the American Medical Association.

Walter B. Tinsley, M.D.

Dr. Walter B. Tinsley, 86, an Indianapolis physician for more than half a century, died July 15 in Hoosier Village, where he lived.

A former instructer in dermatology at the Indiana University School of Medicine, Dr. Tinsley graduated from that school in 1913 and interned at the Indianapolis City Hospital. He was director of the Venereal Disease Clinic at Marion County General Hospital until his retirement in 1969.

He was a member of the Cincinnati Dermatological Society and was a Senior Member of the Marion County Medical Society and the American Medical Association. In 1963 he became a member of the ISMA Fifty-Year Club.

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NOTICE

Commercial announcements are carried in the Journal as a special service to ISMA members. Only advertisements considered to be of advantage to members by the Journal editorial board will be accepted. Those of a truly commercial nature (i.e., firms selling brand products, services, etc.) will be considered for display type advertising.

Charges for commercial announcements are:

First four lines: $3.00
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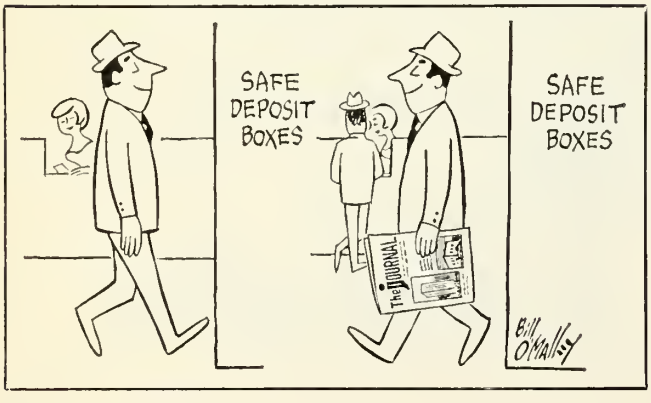
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Offical Call to the House of Delegates

The next annual session of the Indiana State Medical Association will be held at the Indiana Convention-Exposition Center, Indianapolis, Indiana, October 4, 5, 6, 7 and 8, 1974.

The House of Delegates will be constituted as follows: Marion County, twenty-two delegates; Lake County, nine delegates; Allen County, six delegates; St. Joseph and Vanderburgh county societies, each five delegates; Delaware-Blackford, Owen-Monroe, Tippecanoe and Wayne-Union county societies, each three delegates; Bartholomew-Brown, Daviess-Martin, Dearborn-Ohio, Elkhart, Fayette-Franklin, Fountain-Warren, Grant, Harrison-Crawford, Jackson-Jennings, Jefferson-Switzerland, LaPorte, Madison, Parke-Vermillion, Porter and Vigo county societies, each two delegates; the other fifty-five county societies, each one delegate; fourteen trustees and the ex-presidents, namely, Herman M. Baker, M. C. Topping, Kenneth L. Olson, Earl W. Mericle, Guy A. Owsley, Maurice E. Glock, Donald E. Wood, Joseph M. Black, Kenneth O. Neumann, Eugene S. Rifner, Patrick J. V. Corcoran, Lowell H. Steen, Malcolm O. Scamahorn, Peter R. Petrich and James H. Gosman. The delegate or their designated alternate delegate elected by their respective section shall also be a member but without power to vote. The following shall be ex officio members: the president, president-elect, the executive secretary, the treasurer, the assistant treasurer, the speaker, the vice-speaker and the delegates to the American Medical Association, all without power to vote, except in case of a tie vote, when the president or person presiding shall cast the deciding vote. Two delegates are to be selected by the Indiana Chapter Student American Medical Association who shall be seated though without power to vote.

All delegates must present their credentials card certified by their county medical society before being seated as a delegate. No delegate will be seated without proper certification.

The House of Delegates will convene promptly at 9:00 a.m., EST, Friday, October 4, 1974, in Ballroom of the Columbia Club, Indianapolis. The second meeting of the House of Delegates will meet from 4:00 p.m., to 6:00 p.m., Monday, October 7, in the Convention Center, and the final session of the House of Delegates will convene at 2:00 p.m., Tuesday, October 8, in the Indiana Convention-Exposition Center.

The order of business will be as follows:

1. Call to order by the president.
2. Invocation.
3. Roll and seating of qualified delegates.
4. Announcements from the chair.
5. Tribute to members of the House or those who served the association in an official capacity and who have died since the 1973 session.
6. Reading of the minutes of previous meetings.
7. Introduction of guests.
8. President's address.
9. Appointment of Reference Committees and assignment of meeting rooms.
10. Unfinished business.
11. Address of the president-elect.
12. Report of president of the Woman's Auxiliary.
13. Report of Indiana Chapter Student AMA.
14. Report of president of Blue Shield.
15. Report of executive secretary.
16. Report of treasurer.
17. Report of chairman of the Board.
18. Reports of trustees.
19. Report of *The Journal* editor.
20. Report of AMA delegates.
21. Report of State Board of Medical Registration and Examination.
22. Reports of committees and commissions.

COMMITTEES

(1) Executive
(2) Grievance
(3) Future Planning
(4) Student Loan
(5) Medical-Legal Review
(6) Sports and Medicine

COMMISSIONS

(1) Aging
(2) Constitution and Bylaws
(3) Convention Arrangements
(4) Emergency Medical Services
(5) Governmental Medical Services
(6) Interprofessional Relations
(7) Legislation
(8) Medical Economics and Insurance
(9) Medical Education and Licensure
(10) Public Health
(11) Public Information
(12) Special Activities
(13) Voluntary Health Agencies
(14) Specialty Medicine

23. New Business:
    (1) Matters referred by the Board of Trustees
    (2) Matters referred by the Executive Committee
    (3) Resolutions
    (4) Selection of city for 1979 meeting
        1975—French Lick—October 18-23
        1976—Indianapolis—October 9-14
        1977—Indianapolis—October 10-14
        1978—French Lick—October 14-19

The election of officers will be first order of business at the final meeting of the House of Delegates. In addition to the regular officers, the terms of the following AMA delegates and alternates expire December 31, 1974, and their successors must be elected at the session: delegates to the American Medical Association to succeed James A. Harshman, Kokomo, Eugene F. Senseny, Fort Wayne, and Malcolm O. Scamahorn, Pittsboro; alternate delegates to succeed A. Alan Fischer, Indianapolis, Ross L. Egger, Daleville, and Kenneth O. Neumann, Lafayette.

Delegates from the First, Fourth, Seventh, Tenth and Thirteenth Districts are reminded that the terms of their trustees will expire October 8, 1974, and new trustees should be elected to succeed the following:

First—Bernard B. Rosenblatt, Evansville
Fourth—Howard C. Jackson, Madison
Seventh—John O. Butler, Indianapolis
Tenth—Vincent J. Santare, Munster
Thirteenth—G. Beach Gattman, Elkhart

Some of these elections may already have been held, but they should be reported to the House of Delegates at this session for confirmation.

JAMES A. WAGGENER, Executive Secretary.

HOUSE OF DELEGATES

Indiana State Medical Association
Indianapolis—October 4, 5, 6, 7 and 8, 1974

County and Delegates	Alternates
ADAMS (1)	
Norman E. Beaver, Berne	
ALLEN (6)	
William R. Cast, Fort Wayne	William C. Ashman, Fort Wayne
Fred W. Dahling, New Haven	John R. Thomas, Fort Wayne
DeWayne L. Hull, Fort Wayne	Jerry H. Connelly, Fort Wayne
Thomas A. Felger, Fort Wayne	Thomas L. Herendeen, Fort Wayne
Michael J. Mastrangelo, Fort Wayne	John M. Hoog, Fort Wayne
Marvin E. Priddy, Fort Wayne	Harry D. Tunnell, Fort Wayne
BARTHOLOMEW-BROWN (2)	
C. David Ryan, Columbus	
Robert M. Seibel, Nashville	
BENTON (1)	
Donald L. McKinney, Otterbein	
BOONE (1)	
Don W. Boyer, Lebanon	
CARROLL (1)	
T. Neal Petry, Delphi	
CASS (1)	
Richard L. Glendening, Logansport	Russell J. Morrical Logansport
CLARK	
David H. Jones, Charlestown	William L. Voskuhl, Charlestown
CLAY (1)	
Charles E. Moon, Brazil	Robert M. Maurer, Brazil
CLINTON (1)	
Robert A. Hedgcock, Frankfort	Harry T. Stout, Frankfort
DAVIESS-MARTIN (2)	
Robert H. Rang, Washington	Marshall H. Seat, Washington
Emory B. Lett, Loogootee	Robert E. Chattin, Loogootee
DEARBORN-OHIO (2)	
Henry W. Conrad, Lawrenceburg	Leslie M. Baker, Aurora
Gordon S. Fessler, Rising Sun	
DECATUR (1)	
Robert P. Acher, Greensburg	Alfredo Q. Paje, Greensburg

County and Delegates	Alternates
DE KALB (1)	
John C. Harvey, Auburn	H. V. Hippensteel, Auburn
DELAWARE-BLACKFORD (3)	
Warren L. Bergwall, Muncie	Larry Cole Yorktown
Paul E. Burns, Hartford City	S. T. Sulit, Hartford City
Ross Egger, Daleville	Richard L. Reedy, Muncie
DUBOIS (1)	
Daniel C. Drew, Jasper	Victor Borges, Huntingburg
ELKHART (2)	
Patrick B. Campbell, Elkhart	James R. Miller, Wakarusa
Frederick W. Bigler, Goshen	Virgil R. Graber, Elkhart
FAYETTE-FRANKLIN (2)	
William F. Kerrigan, Connersville	
Perry F. Seal, Brookville	
FLOYD (1)	
Everett E. Bickers, Floyd Knobs	William V. Johnson, New Albany
FOUNTAIN-WARREN (2)	
Max N. Hoffman, Covington	Lowell R. Stephens, Covington
A. S. Salvo, Williamsport	Carl A. Nelson, West Lebanon
FULTON (1)	
Joseph D. Richardson, Rochester	P. D. Aluning, Rochester
GIBSON (1)	
Roland E. Weitzel, Princeton	
GRANT (2)	
Robert M. Brown, Marion	Shirley Khalouf, Marion
Herbert C. Khalouf, Marion	Charles R. Kershner, Marion
GREENE (1)	
William R. Powers, Lyons	Carl M. Porter, Jasonville
HAMILTON (1)	
A. Adrian Lanning, Noblesville	
HANCOCK (1)	
James T. Anderson, Greenfield	James L. Garrison, Cumberland

County and Delegates	Alternates
HARRISON-CRAWFORD (2)	
Carl Dillman, Corydon	
HENDRICKS (1)	
Eric D. Clark, Plainfield	
HENRY (1)	
Kenneth G. Hill, New Castle	Frank C. McDonald, New Castle
HOWARD (1)	
Jack W. Higgins, Kokomo	Richard P. Miethke, Kokomo
JACKSON-JENNINGS (2)	
John C. Linson, Seymour	William F. Blaisdell, Seymour
William A. Johnson, North Vernon	
JASPER (1)	
Ernest R. Beaver, Rensselaer	
JAY (1)	
James S. Fitzpatrick, Portland	Eugene M. Gillum, Portland
JEFFERSON-SWITZERLAND (2)	
Ott B. McAtee, Madison	Warren R. Rucker, Madison
JOHNSON (1)	
Joseph W. Young, Greenwood	John M. Records, Franklin
KNOX (1)	
Norbert M. Welch, Vincennes	
KOSCIUSKO (1)	
Wymond B. Wilson, Mentone	David W. Hines, Warsaw
LA GRANGE (1)	
Michael O. Mellinger, LaGrange	Allen S. Martin, Shipshewana
LAKE (9)	
Henry L. Lebioda, Gary	Reginald R. Barton, Gary
Walfred A. Nelson, Gary	John J. Reed, Hobart
Thomas C. Tyrrell, Hammond	Donald H. Rudser, Whiting
William G. Grosso, East Chicago	
David E. Ross, Gary	Lee H. Trachtenberg, Munster
Theodore R. Espy, Gary	Walter A. Repay, Munster
Charles D. Egnatz, Schererville	Peter E. Gutierrez, Crown Point
Nicholas L. Polite, Hammond	S. A. Gonzalez, Highland
Leonard W. Neal, Munster	
LA PORTE (2)	
John Luce, Michigan City	Peter J. Pilecki, Michigan City
Fred S. Carter, LaPorte	Barbara Backer, LaPorte
LAWRENCE (1)	
James L. Mount, Bedford	Florian S. Dino, Bedford

County and Delegates	Alternates
MADISON (2)	
Ted S. Doles, Middletown	John D. Jones, Anderson
Lawrence E. Allen Anderson	Robert W. McCurdy, Anderson
MARION (22)	
John W. Beeler, Indianapolis	Berj Antreasian, Indianapolis
Albert M. Donato, Indianapolis	James F. Balch, Indianapolis
A. Alan Fischer, Indianapolis	Albert L. Blake, Indianapolis
Ted H. Gabrielson, Indianapolis	Richard A. Brickley, Indianapolis
Karl M. Koons, Indianapolis	Rolla D. Burghard, Indianapolis
E. Henry Lamkin, Indianapolis	Fred R. Brooks, Indianapolis
Thomas J. Lord, Indianapolis	Helen G. Czenkusch, Indianapolis
George T. Lukemeyer, Indianapolis	Frank W. Fortuna, Beech Grove
Loren H. Martin, Indianapolis	John D. Graham, Indianapolis
B. T. Maxam, Indianapolis	William E. Graham, Indianapolis
I. E. Michael, Indianapolis	Kenneth L. Gray, Indianapolis
John G. Pantzer, Indianapolis	Russell L. Judd, Indianapolis
George F. Parker, Jr. Indianapolis	Gerald H. Kurlander, Indianapolis
Arvine G. Popplewell, Indianapolis	Michael W. Manzie, Indianapolis
D. Edmund Storey, Indianapolis	John D. Moriarty, Indianapolis
Charles E. Test, Indianapolis	Paul F. Muller, Indianapolis
Hugh K. Thatcher, Jr., Indianapolis	Stafford W. Pile, Indianapolis
Charles R. Thomas, Indianapolis	John N. Pittman, Indianapolis
Hugh L. Williams, Indianapolis	George H. Rawls, Indianapolis
Malcolm L. Wrege, Indianapolis	Loyd K. Stump, Indianapolis
Fred L. Toumey, Indianapolis	Douglas H. White, Indianapolis
Morris E. Thomas, Indianapolis	Dennis J. Nicholas, Indianapolis
MARSHALL (1)	
James S. Robertson, Plymouth	
MIAMI (1)	
Lloyd Hill, Peru	
MONTGOMERY (1)	
Richard R. Egger, Crawfordsville	James M. Kirtley, Crawfordsville
MORGAN (1)	
Kenneth E. Comer, Mooresville	
NOBLE (1)	
Carl F. Stallman, Kendallville	Max Sneary, Avilla
ORANGE (1)	
Phillip T. Hodgin, Orleans	Charles X. McCalla, Paoli

County and Delegates	Alternates
OWEN-MONROE (3)	
William R. Anderson, Bloomington	Charles W. McClary, Bloomington
Roger F. Robison, Bloomington	Charles L. McKeen, Bloomington
Robert E. Rose, Spencer	Rodger L. Buck, Spencer
PARKE-VERMILLION (2)	
Franklin Swaim, Rockville	
Antolin M. Montecillo, Clinton	Milton Herzberg, Clinton
PERRY (1)	
Fred Smith, Jr., Tell City	Robert A. Ward, Tell City
PIKE (1)	
Donald L. Hall, Petersburg	
PORTER (2)	
Joel I. Hull, Chesterton	James R. Brown, Valparaiso
Martin J. O'Neill, Valparaiso	Alfred J. Kobak, Jr., Valparaiso
POSEY (1)	
L. John Vogel, Mt. Vernon	John R. Crist, Mt. Vernon
PULASKI (1)	
William R. Thompson, Winamac	Charles E. Heinsen, Winamac
PUTNAM (1)	
Fred E. Haggerty, Greencastle	
RANDOLPH (1)	
Lowell W. Painter, Winchester	B. D. Wagoner, Union City
RIPLEY (1)	
Manuel G. Garcia, Batesville	William J. Warn, Milan
RUSH (1)	
Frank H. Green, Rushville	Harry G. McKee, Rushville
ST. JOSEPH (5)	
George M. Haley, South Bend	Wallace S. Tirman, South Bend
Alfred C. Cox, South Bend	Robert F. Reed, Mishawaka
Donald G. White, South Bend	Gordon C. Cook, South Bend
Samuel E. Bechtold, South Bend	Charles F. Martin, South Bend
Charles O. Hamilton, South Bend	Richard A. Schaphorst, Mishawaka
SCOTT (1)	
Marvin L. McClain, Scottsburg	Eusebio Kho, Scottsburg
SHELBY (1)	
Wilson L. Dalton, Shelbyville	
SPENCER (1)	
John H. Barrow, Dale	
STARKE (1)	
W. Allen Palmer, Knox	Herbert C. Ufkes, North Judson
STEUBEN (1)	
R. Wyatt Weaver, Angola	Donald G. Mason, Angola

County and Delegates	Alternates
SULLIVAN (1)	
Betty Dukes, Dugger	Glen McClure, Sullivan
TIPPECANOE (3)	
George M. Underwood, Lafayette	Robert E. Hannemann, Lafayette
George B. Davis, Lafayette	John A. Knote, Lafayette
David M. Jones, Lafayette	Ben Z. Klatch, Lafayette
TIPTON (1)	
Meredith B. Gossard, Tipton	William A. Kurtz, Tipton
VANDERBURGH (5)	
Jerry D. Becker, Evansville	William H. Getty, Evansville
Forest F. Radcliff, Evansville	James A. Marvel, Evansville
John D. Wilson, Evansville	John E. Heumann, Evansville
Albert S. Ritz, Evansville	Charles W. Hachmeister, Evansville
Ray H. Burnikel, Evansville	Donald C. Buehner, Evansville
VIGO (2)	
William G. Bannon, Terre Haute	Paul E. Humphrey, Terre Haute
Thomas J. Conway, Terre Haute	William L. Strecker, Terre Haute
WABASH (1)	
Wilbur D. McFadden, North Manchester	David L. Ellis, Wabash
WARRICK (1)	
Carlos M. Ruiz, Boonville	Ernesto M. Camacho, Boonville
WASHINGTON (1)	
C. Stanly Manship, Hardinsburg	
WAYNE-UNION (3)	
Tom S. Shields, Richmond	Glen Ward Lee, Richmond
James R. Daggy, Richmond	Joseph J. Zore, Richmond
William B. McWilliams, Liberty	Artemi Jaco, Liberty
WELLS (1)	
Truman E. Caylor, Bluffton	Louis F. Bradley, Bluffton
WHITE (1)	
Max L. Fields, Monticello	Gerald R. Bougher, Monticello
WHITLEY (1)	
Thomas Hamilton, Columbia City	C. Jules Heritier, Columbia City
INDIANA STUDENT AMA (2)	
Schuyler Geller, Indianapolis	
Maria R. Ferraro Indianapolis	
SECTION DELEGATES (16)	
Allergy	
Anesthesiology	
Cutaneous Medicine	

Section and Delegates	Alternates
College Health Physicians	
Floyd Thurston, Bloomington	James Greenlee, Bloomington
Family Physicians	
George B. Keenan, Indianapolis	
Internal Medicine	
Stephen Olvey, Indianapolis	
Directors of Medical Education	
Jack Hall, Indianapolis	W. Thomas Spain, Evansville
Nervous and Mental Diseases	
Gene E. Lynn, Indianapolis	Richard N. French, Indianapolis
Obstetrics and Gynecology	
Ophthalmology and Otolaryngology	
Pathology and Forensic Medicine	
Pediatrics	
Public Health and Preventive Medicine	
David Edwards, Indianapolis	James S. Robertson, Plymouth
Radiology	
Surgery	
Urology	

Officers

President—Joe Dukes, Dugger
President-elect—Gilbert M. Wilhelmus, Evansville
Chairman, Executive Committee—Donald M. Kerr, Bedford
Member, Executive Committee—William R. Clark, Sr., Fort Wayne
Treasurer—Hugh K. Thatcher, Jr., Indianapolis
Assistant Treasurer—Arvine G. Popplewell, Indianapolis
Chairman of the Board—Vincent J. Santare, Munster
Editor—Frank B. Ramsey, Indianapolis
Executive Secretary—James A. Waggener, Indianapolis

Trustees

1st District—Bernard B. Rosenblatt, Evansville
2nd District—Paul W. Holtzman, Bloomington
3rd District—Eli Goodman, Charlestown
4th District—Howard C. Jackson, Madison
5th District—Cleon M. Schauwecker, Greencastle
6th District—Paul M. Inlow, Shelbyville
7th District—John O. Butler, Indianapolis
7th District—Joseph F. Ferrara, Franklin
8th District—Richard G. Ingram, Montpelier
9th District—William M. Sholty, Lafayette
10th District—Vincent J. Santare, Munster
11th District—James A. Harshman, Kokomo
12th District—John S. Farquhar, Jr., Fort Wayne
13th District—G. Beach Gattman, Elkhart

Past Presidents

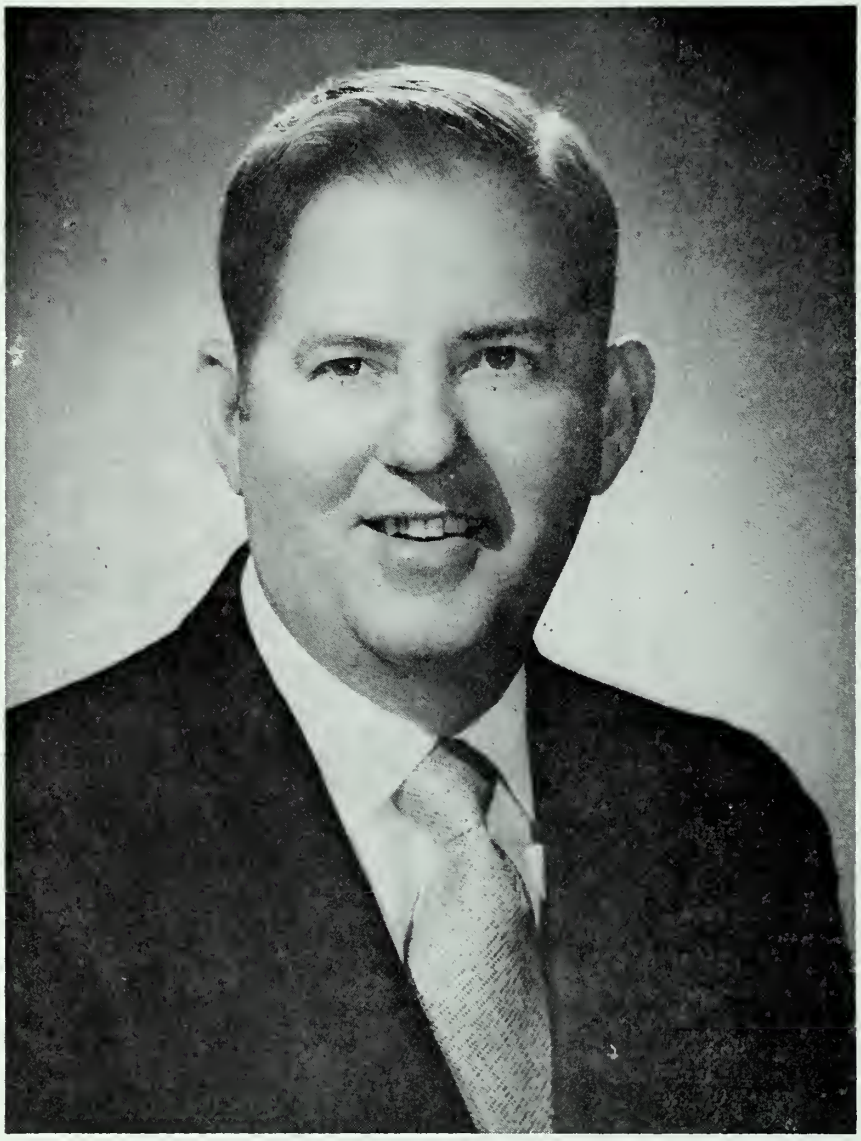
Herman M. Baker, Evansville
M. C. Topping, Terre Haute
Kenneth L. Olson, South Bend
Earl W. Mericle, Indianapolis
Guy A. Owsley, Hartford City
Maurice E. Glock, Fort Wayne
Donald E. Wood, Indianapolis
Joseph M. Black, Seymour
Kenneth O. Neumann, Lafayette
Eugene S. Rifner, Van Buren
Patrick J. V. Corcoran, Evansville
Lowell H. Steen, Hammond
Malcolm O. Scamahorn, Pittsboro
Peter R. Petrich, Attica
James H. Gosman, Indianapolis

AMA Delegates

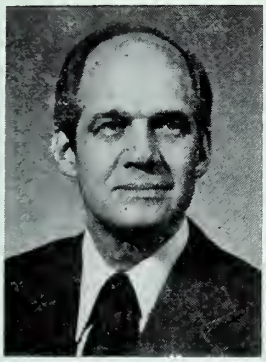
James A. Harshman, Kokomo
Eugene F. Senseny, Fort Wayne
Malcolm O. Scamahorn, Pittsboro
Patrick J. V. Corcoran, Evansville
Lowell H. Steen, Hammond

Fifty-Year Club—1974

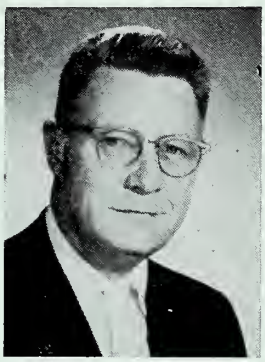
ALLEN COUNTY
Ralph W. Elston, Fort Wayne
BARTHOLOMEW-BROWN COUNTY
Edwin L. Libbert, Columbus
Dorothy Teal, Columbus
DELAWARE-BLACKFORD COUNTY
Elmer T. Cure, Muncie
DUBOIS COUNTY
Henry G. Backer, Ferdinand
ELKHART COUNTY
Paul H. Martin, Elkhart
GIBSON COUNTY
Virgil McCarty, Princeton
GRANT COUNTY
Russell W. Lavengood, Marion
KNOX COUNTY
Robert G. Moore, Bicknell
KOSCIUSKO COUNTY
John R. Baum, Warsaw
LAKE COUNTY
Walter M. Behn, Wheaton, Illinois
Georgianna Lutz, Gary
Philip J. Rosenbloom, Gary
MARION COUNTY
Robert M. Dearmin, Indianapolis
John E. Owen, Indianapolis
Martha C. Souter, Indianapolis
Fred A. Thomas, Indianapolis
John E. Wyttenbach, Indianapolis
PARKE-VERMILLION COUNTY
Casper Harstad, Rockville
PERRY COUNTY
Hargis R. Bush, Cannelton
RANDOLPH COUNTY
William S. Dininger, Winchester
ST. JOSEPH COUNTY
Marcus M. Gilman, South Bend
George F. Green, South Bend
Louis E. How, Lakeville
Thomas B. Pauszek, South Bend
George M. Rosenheimer, South Bend
Harry H. Sandoz, South Bend
VANDERBURGH COUNTY
Roscoe L. Kleindorfer, Evansville
WELLS COUNTY
Truman E. Caylor, Bluffton
WAYNE-UNION COUNTY
Paul S. Rhoads, Richmond
WHITLEY COUNTY
Otto F. C. Lehmberg, Columbia City



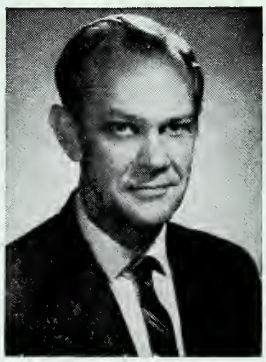
JOE DUKES, M.D.
President
Indiana State Medical Association
1973-1974



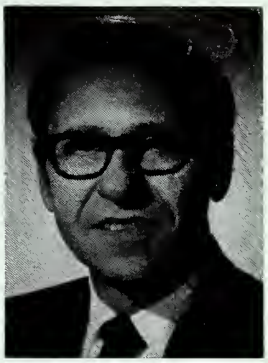
GILBERT WILHELMUS, M.D.
President-Elect
Evansville



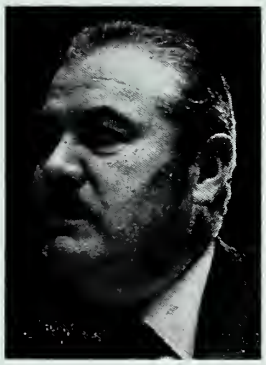
HUGH K. THATCHER, JR., M.D.
Treasurer
Indianapolis



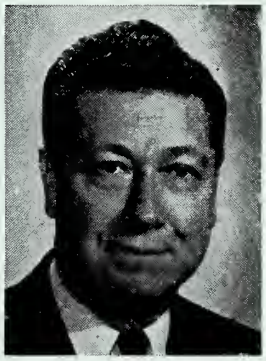
DONALD M. KERR, M.D.
Chairman
Executive Committee
Bedford



VINCENT J. SANTARE, M.D.
Chairman of Board
Munster



ARVINE POPPLEWELL, M.D.
Assistant Treasurer
Indianapolis



WILLIAM R. CLARK, M.D.
Executive Committee
Fort Wayne



MRS. BETH BOWEN
President Auxiliary
Indianapolis



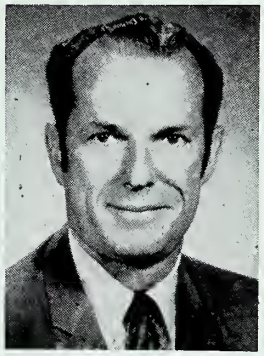
JAMES A. WAGGENER
Executive Secretary
Indianapolis



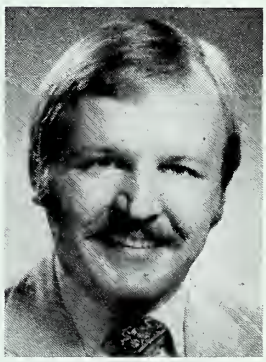
KENNETH W. BUSH
Administrative Assistant
Indianapolis



ROBERT J. AMICK
Field Secretary
Scottsburg



HOWARD GRINDSTAFF
Field Secretary
Indianapolis



MICHAEL McDERMOTT
Legislative Assistant
Brownsburg

Board of Trustees



BERNARD ROSENBLATT, M.D.
Evansville



PAUL W. HOLTZMAN, M.D.
Bloomington



ELI GOODMAN, M.D.
Charlestown



HOWARD C. JACKSON, M.D.
Madison



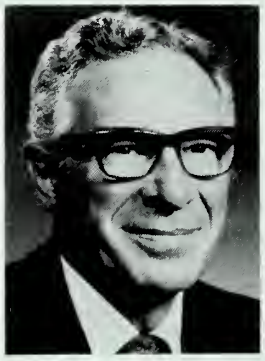
CLEON M. SCHAUWECKER, M.D.
Greencastle



PAUL M. INLOW, M.D.
Shelbyville



JOHN O. BUTLER, M.D.
Indianapolis



JOSEPH F. FERRARA, M.D.
Franklin



RICHARD INGRAM, M.D.
Montpelier



WILLIAM M. SHOLTY M.D.
Lafayette



VINCENT J. SANTARE, M.D.
Munster



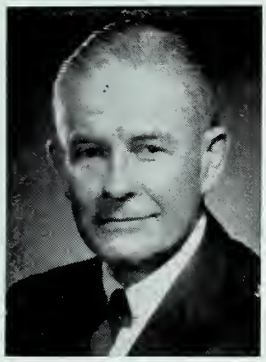
JAMES A. HARSHMAN, M.D.
Kokomo



JOHN S. FARQUHAR, JR., M.D.
Fort Wayne



G. BEACH GATTMAN, M.D.
Elkhart



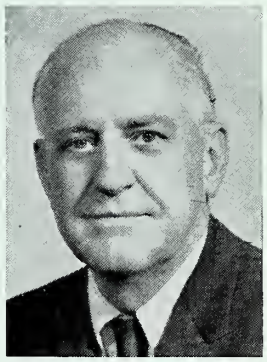
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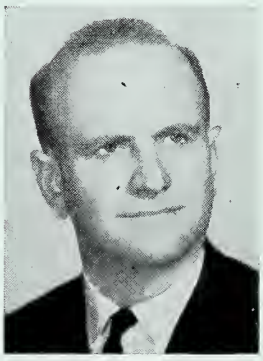
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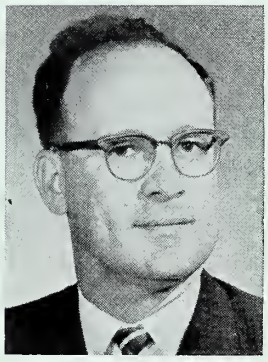
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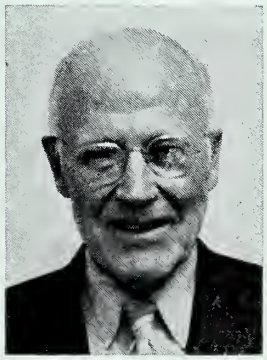
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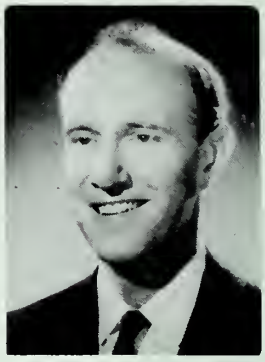
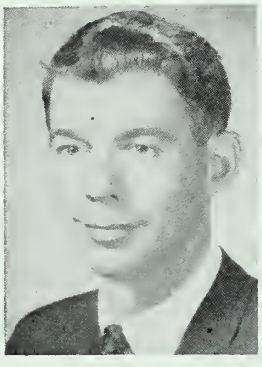
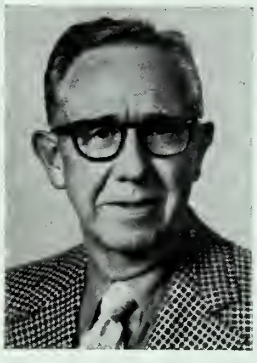
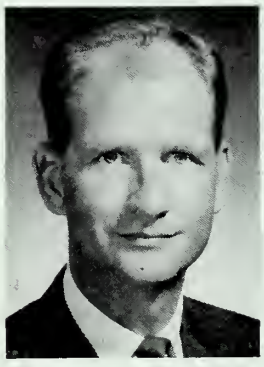


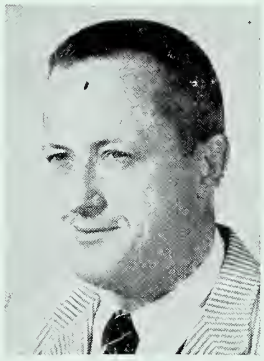
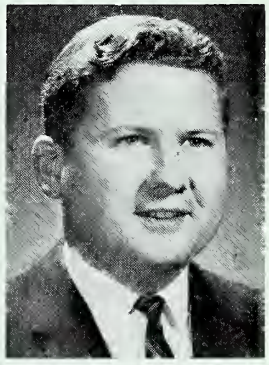
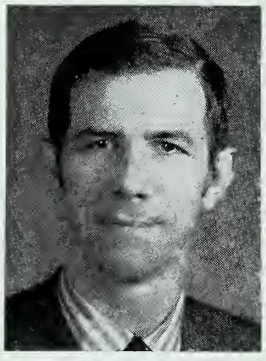
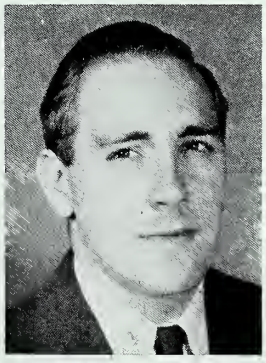
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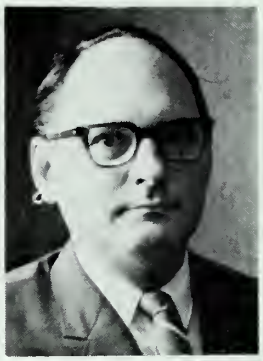


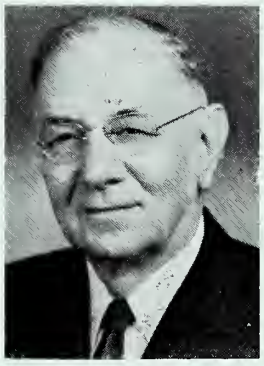
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Schedule of Events

125th Annual Convention
Indiana Convention-Exposition Center
100 S. Capitol Avenue
Indianapolis, Indiana

(All Events will be on Eastern Standard Time)

(The scientific program for the 125th annual convention of the Indiana State Medical Association is acceptable for 14 ¾ prescribed and 5 elective hours by the American Academy of Family Physicians. The prescribed hours are for attendance at the Family Physicians Section meeting.)

(An AMA Continuing Education Accreditation team will determine ISMA convention Physician Recognition Award credits.)

Thursday, October 3, 1974

8:00 a.m. to 5:00 p.m. — 20th Postgraduate Seminar for Local Health Officers on Current Developments in Public Health, Parlor B Columbia Club

3:00 p.m. — Executive Committee Meeting, Columbia Club

6:00 p.m. — Women Physicians Dinner, Black Curtain Dinner Theater, 2145 N. Talbott Ave., "6 rms riv. vu."

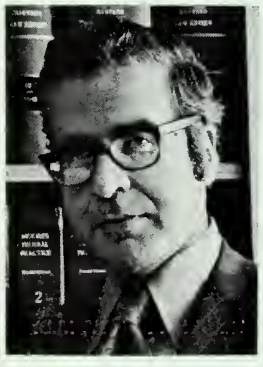
6:00 p.m. — Board of Trustees Meeting (Dinner), Columbia Club

Friday, October 4, 1974

8:00 a.m. — Seminar for Local Health Officers, Parlor B, Columbia Club

House of Delegates

9:00 a.m. — House of Delegates Meeting, Columbia Club Ballroom



ARTHUR R. MILLER
Combridge, Moss.

Professor, Harvard Low School; Member, Speciol Legislative Commission on Privacy (Mass.), chairman, Governor's Special Commission on Privacy and Persanal Data (Mass.); member, ABA Committee on Scientific and Ecanomic Proof; LL.B. degree from Horvard Law School, mogno cum laude, 1958.

12 noon — IMPAC Luncheon, Indianapolis Hilton
Speaker: Arthur R. Miller, LL.B., "CONFIDENTIALITY OF MEDICAL CARE — CAN IT BE EFFECTIVELY PRESERVED?"
(Auxiliary Members invited)

2:00 p.m. — Reference Committee Meetings, Columbia Club

Golf and Tennis Tournaments

10:00 a.m. — Tennis Tournament, Highland Golf and Country Club (Dr. Dean Grove, Indianapolis, Chairman)

10:00 a.m. to 12:00 noon — Men's singles

1:00 p.m. — Men's doubles (feature event)

10:00 a.m. to 5:00 p.m. — Women's tennis

1:00 p.m. — Golf Tournament, Highland Golf and Country Club (1050 W. 52nd Street) Tee times: 1:00 p.m. and after (Dr. Malcolm Wrege, Indianapolis, Chairman)

7:00 p.m. — Cocktail hour

8:00 p.m. — Awards banquet
(Tennis and golf)

Friday, October 4, 1974

Section on Surgery, Indiana Chapter, American College of Surgeons, and Indiana Chapter International College of Surgeons

Columbia Club Main Dining Room

6:00 p.m. Cocktails and Dinner
"THE APPROACH TO THE PATIENT WITH CARCINOMA OF THE BREAST," Richard E. Wilson, Boston
Business Meeting of the Section, American College and International College
PANEL DISCUSSION — Moderator: John E. Jesseph, M.D., Indianapolis. Panel Members: J. Robert Edwards, M.D., Auburn; Richard N. Smith, M.D., Indianapolis; Glen McClure, M.D., Sullivan

8:00 p.m. Trustees Annual Dinner, Columbia Club

Saturday, October 5, 1974

8:00 a.m. Grand Rounds—Wile Hall, Methodist Hospital

10:30 a.m. Buses will leave the Hilton Hotel, for I. U. vs. W. Va. football game at Bloomington, returning to the Athenaeum after the game. Box lunches will be available.

7:30 p.m. Oktoberfest — Athenaeum, 401 E. Michigan Street (sponsored by the Woman's Auxiliary)

Sunday, October 6, 1974

Art and Hobby Show, Convention Center Mezzanine

9:00 a.m. Registration Begins

12 noon Opening of technical and scientific exhibits

12:00 noon Church Service, Room 201 Convention Center—Sponsored by Woman's Auxiliary

12:15 p.m. Buffet Luncheon, Rooms 202-203-204 Convention Center

12:15 p.m. Past Presidents Luncheon, Room 219 Convention Center

Section on Radiology and Indiana Roentgen Society, Inc.

Rooms 217-218 Convention Center

9:30 a.m. Executive Committee Meeting

10:30 a.m. Business Meeting

11:00 a.m. Presentation — "UPDATE ON RADIOLOGIST INVOLVEMENT IN PSRO," John C. Spellmeyer, M.D., Richmond

12 noon Luncheon

1:00 p.m. "RADIOLOGY MANPOWER SURVEY," Eugene C. Klatte, M.D., Indianapolis
Election of 1975 Section Officers



RICHARD E. WILSON, M.D.
Bastan

Professor af Surgery, Harvard Medical Schaal; Surgeon and Directar af the Transplantation and Oncalagy Services, Peter Bent Brigham Haspital; consultant, Veterans Administration Haspital, West Raxbury, Mass.; specialty in general surgery; M.D. degree from State University of New York Medical School in 1951.

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ISMA MEDICAL ASSISTANT'S PROGRAM

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No charge for registration; however, do register at Convention Registration. Send to: Neva Y. Arnold, RN, CMA, 5470 E. 16th St., Indianapolis, IN 46218



EUGENE C. KLATTE, M.D.
Indianapalis

Chairman of the Department af Radiology, Indiana University Medical Center; diplamate, American Baard of Radialogy (Guest Examiner, 1964-68); M.D. degree fram Indiana University Schaal of Medicine, 1952.



THE REV. WILLIAM S. HOGSETT
Indianapolis

Chaplain, Community Hospital; member, Association for Clinical Pastaral Educatian, International Transactianal Analysis Asaciatian and College of Chaplains; B.A., Indiana; S.T.B., Bostan; M.A., Butler.



MRS. JUNE HALL, C.M.A.-A.
Danville, Ill.

Past-President, Illinois Society, AAMA; Speaker of the House of Delegates, AAMA, and editar, The Certified Medical Assistant; certified as Administrative Medical Assistant in 1969; employed as an Administrative Medical Asstistant in Danville for 14 years.



RAY C. SMITH, JR., M.D.
Indianapolis

Fellow, American College of Surgeons; was a missionary doctor in Saigon, Viet Nam, far six years; M.D. degree from Lama Linda University; Completed three-year surgical residency at Pontiac General Haspital, Mich., in 1957. On Board af Directors of Marion County and Indiana Division of the American Cancer Society.



BRANDT F. STEELE, M.D.
Denver, Colo.

Professor of Psychiatry, University of Colorado Medical Center; Teaching Analyst, Denver Psychoanalytic Institute; Chief Psychiatrist, National Center for Prevention and Treatment of Child Abuse and Neglect; specialty in psychiatry and psychoanalysis; M.D. degree from I.U. School af Medicine in 1932.



ROBERT L. BAEHNER, M.D.
Indianapalis

Professor of Pediatrics, I.U. School of Medicine, and Director of Pediatric Hematology-Oncology, Riley Children's Hospital; established investigator, A.H.A.; specialty in childhood cancer and blood disorders; M.D. degree from University of Cincinnati Medical School in 1960.

Sunday, October 6, 1974

Indiana Society, American Association of Medical Assistants, Inc.

Room 226 Convention Center

CHALLENGE TOWARD EXCELLENCE

9:00 a.m.	Registration
9:30 a.m.	"PATIENTS ARE PEOPLE," (I'm O.K., You're O.K.), William Hogsett, M.A., Chaplain, Community Hospital, Indianapolis
10:30 a.m. to 10:45 a.m.	Time allowed to visit exhibits
10:45 a.m.	"ORGANIZING YOUR TIME, PERSONAL AND PROFESSIONAL," Mrs. June Hall, CMA, Danville, Ill.
12:15 p.m.	Buffet Luncheon, Rooms 202-203-204 Convention Center
1:15 p.m.	"DEALING WITH DISASTER IN A PHYSICIAN'S OFFICE," Joseph McPike, M.D., Carmel
2:15 p.m. to 2:45 p.m.	Time allowed to view exhibits
2:45 p.m.	"ILEAL BYPASS SURGERY," Ray C. Smith, Jr., M.D., Indianapolis

General Scientific Meeting

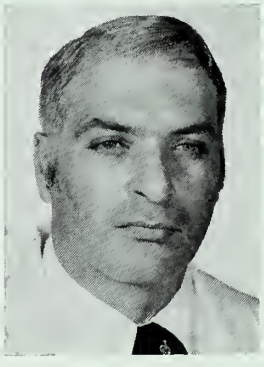
Rooms 210-211-212 Convention Center

(Sponsored jointly by ISMA and Riley Memorial Association. Open to all physicians, their wives and guests.)

Joe Dukes, M.D., Presiding

HONORING THE 50TH ANNIVERSARY OF THE RILEY HOSPITAL FOR CHILDREN

2:00 p.m.	"CHILD ABUSE: ITS IMPACT ON SOCIETY," Brandt F. Steele, M.D., Denver, Colo.
2:30 p.m.	"RECENT ADVANCES IN CHILDHOOD CANCER," Robert L. Baehner, M.D., Indianapolis, Jay L. Grosfeld, M.D., Indianapolis
3:00 p.m. to 3:30 p.m.	Time allowed to view exhibits



JAY L. GROSFELD,
Indianapolis

Professar af Surgery and Director of Pediatric Surgery, I.U. School of Medicine; Surgeon-in-Chief, Riley Hospital for Children; M.D. degree from New York University School of Medicine, 1961.

Sunday, October 6, 1974

3:30 p.m. "RECENT ADVANCES IN PEDIATRIC GASTROENTEROLOGY," Joseph F. Fitzgerald, M.D., Indianapolis

4:00 p.m. "RECENT ADVANCES IN PERINATOLOGY," Edwin L. Gresham, M.D., Indianapolis

Section on Nervous and Mental Diseases and Indiana Psychiatric Society

Room 215 Convention Center

3:00 p.m. Informal presentation by Brandt Steele, M.D., Denver, Colo.
(Merck Sharp and Dohme is sponsoring Dr. Steele's participation in the program.)

6:15 p.m. Reception Fifty Year Club, Columbia Club

6:45 p.m. President's Reception and Dinner, Columbia Club Ballroom, Speaker: Alvin Toffler, author of *Future Shock*

Monday, October 7, 1974

Art and Hobby Show, Mezzanine

8:00 a.m. Board of Trustees Breakfast, Room 226 Convention Center

8:30 a.m. Registration Continues

9:00 a.m. Opening of technical and scientific exhibits

10:00 a.m. Meeting of Small County Delegates, Room 215 Convention Center

12 noon Editorial Board Luncheon, Room 219 Convention Center

12:15 p.m. Association of American Physicians and Surgeons Luncheon, Room 201 Convention Center; price $10.00
Speaker: Representative Philip M. Crane (Ill.)

Section on College Health Physicians

Room 217 Convention Center

1:00 p.m. Business meeting only
Election of 1975 Section Officers

Section on Family Physicians

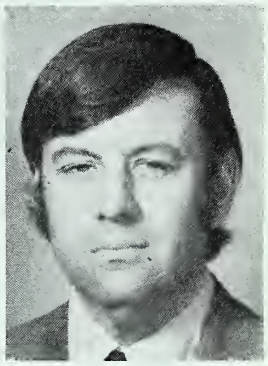
Room 202 Convention Center

Morning session will consist of live, slide or movie demonstrations of some of the technics frequently used in Family Practice.

9:00 a.m. Cleaning an Ear Canal, Alfred E. Hollenberg, M.D., Hagerstown

9:20 a.m. Critique — William T. Edwards, M.D., Pittsboro

9:30 a.m. Question, Answer, Comment



JOSEPH F. FITZGERALD, M.D.
indionopolis

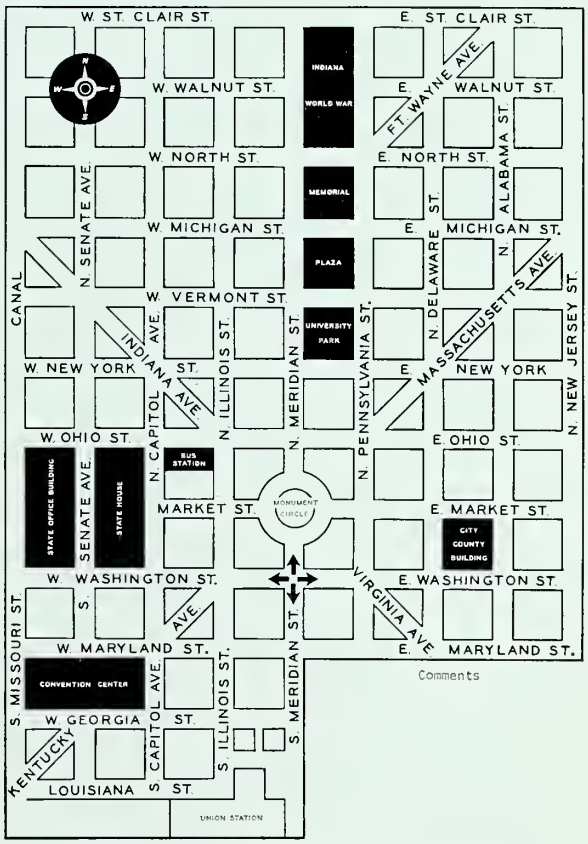
Associote Professor of Pediotrics and Director, Gostrointestinol Diseose Section, I.U. Medical Center, Riley Children's Hospitol; consultant, VA Hospitol and Marion Counly General; Fellow, American Acodemy of Pediotrics; specialty in pediatric gastroenterology; M.D. degree from I.U. School of Medicine in 1965.



ALVIN TOFFLER

Author of "Future Shock" and a former Associote Editor of Fortune magazine; contributor to scholorly journals as well os popular mogoiznes; has served as consultont to the Institute for the Future, the Americon Telephone and Telegraph Co., the Rockefeller Brothers Fund; former Visiting Professor at Cornell University.

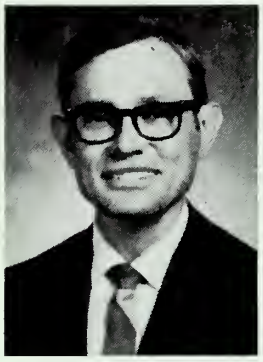
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SPEAKERS



WARREN N. McCLURE, M.D.
Kokomo

M.D. degree from St. Louis University School of Medicine in 1949; diplomate, American Board of Family Practice; in solo practice in Kokomo since 1953.



JAMES R. DAGGY, M.D.
Richmond

Graduate of Northwestern University Medical School in 1951; specialty in family practice.



PAUL A. WILLIAMS, M.D.
Rensselaer

Instructor, Indiana University Medical School; college physician and team physician, St. Joseph College, Rensselaer; diplomate, American Board of Family Practice; Fellow, American Academy of Family Practice; M.D. degree from Tulane University Medical School in 1958.



PAUL L. McHENRY, M.D.
Indianapolis

Chief of Cardiology, Marion County General Hospital; Associate Professor of Medicine, I.U. Medical Center; Fellow, American College of Cardiology and American Heart Association; specialty in cardiology; M.D. degree from University of Cincinnati Medical School in 1961.

Monday, October 7, 1974

9:55 a.m.	Ingrown Toenail, Edward L. Hollenberg, Winamac
10:15 a.m.	Critique — Benjamin A. Ranck, M.D., Columbus
10:25 a.m.	Question, Answer, Comment
10:45 a.m. to 11:15 a.m.	Time allowed to visit exhibits
11:15 a.m.	Sigmoidoscopy, Warren McClure, M.D., Kokomo
11:35 a.m.	Critique — James M. McIntyre, M.D., Indianapolis
11:45 a.m.	Questions, Answers, Comments
12:10 p.m.	Summary of morning
12:15 p.m.	Open Lunch and View Exhibits The afternoon program will be the presentation of guidelines for developing and operating a program of community sports and recreation medicine.
1:30 p.m.	Section Business Meeting Election of 1975 Section Officers
2:00 p.m.	PRESENTATION OF GUIDELINES —James R. Daggy, M.D., Richmond, presiding
	Panel of Experts
	Brad Bomba, M.D., Bloomington, chairman, ISMA Committee on Sports and Medicine
	Alois E. Gibson, M.D., Richmond, member, ISMA Committee on Sports and Medicine
3:00 p.m. to 3:30 p.m.	Time Allowed to View Exhibits
	Charles Hilton, Richmond, president, National Council of Secondary School Athletic Directors
	Mr. Ronald Sendre, athletic trainer, Muncie
	Richard Weisner, M.D., Eaton, family physician
	Paul A. Williams, M.D., Rensselaer, family practice

Section on Internal Medicine, Indiana Society of Internal Medicine and Indiana Chapter, American College of Physicians

Room 204 Convention Center

8:30 a.m.	Welcome — T. W. Alley, M.D., Indianapolis, Program Chairman Presiding—John L. Ferry, M.D., FACP, Hammond
8:35 am.	"EXERCISE CARDIAC TESTING," Paul McHenry, M.D., Indianapolis

Monday, October 7, 1974

9:30 a.m. "PHYSICIANS' ASSISTANTS," Frank A. Riddick, Jr., M.D., New Orleans

10:25 a.m. to 10:35 a.m. Time allowed to view exhibits—Coffee

10:35 a.m. "ARTERIAL BLOOD GASES—DERIVATION AND APPLICATION," Harold Levine, M.D., Chicago

11:30 a.m. Question and Answers

11:45 a.m. Annual Business Meeting
Election of 1975 Section Officers

12:10 p.m. Luncheon, Room 226-227

Afternoon Session

Room 204

Presiding—Donald E. Wood, M.D., FACP, Indianapolis

1:45 p.m. CURRENT ACTIVITIES OF ASIM, Glenn Molyneaux, M.D., San Francisco

2:05 p.m. CURRENT ACTIVITIES OF THE AMERICAN COLLEGE OF PHYSICIANS, Richard W. Vilter, M.D., Cincinnati

2:25 p.m. "PANCREATIC DISEASES," Eugene P. DiMagno, M.D., Rochester, Minn. (G. D. Searle and Company is sponsoring Dr. DiMagno's participation in the program)

3:20 p.m. to 3:35 p.m. Time allowed to view exhibits—Coffee

3:35 p.m. "ACCOUNTABILITY," Charles M. Jacobs, J.D., Chicago

4:30 p.m. Questions and Answers

SPEAKERS



FRANK A. RIDDICK, JR., M.D.
New Orleans

Associate Clinical Professor of Medicine, Tulane University; Associate Medical Director, Ochsner Clinic; Trustee, American Society of Internal Medicine; AMA Council on Health Manpower; AMA representative on National Commission on Certification of Physician's Assistants; diplomate, American Board of Internal Medicine; M.D. degree from Vanderbilt in 1954.



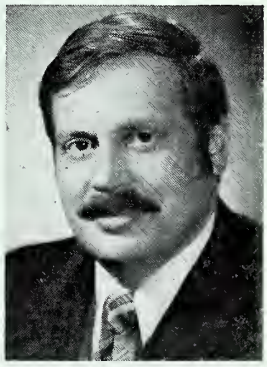
HAROLD LEVINE, M.D.
Chicago

Professor of Medicine, Loyola Stritch School of Medicine; Chief, Pulmonary Disease Section, Hines VA Hospital, Hines, Ill.; "Professor of the Year," Chicago Medical School, 1965; specialty in pulmonary disease, internal medicine; M.D. degree from Chicago Medical School in 1956.



RICHARD W. VILTER, M.D.
Cincinnati

Professor of Medicine and Director, Department of Internal Medicine, University of Cincinnati Medical Center, Cincinnati General Hospital and Holmes Hospital; AMA Award for Outstanding Contributions in the Field of Nutrition, 1960; Chairman, Hematology Study Section, NIH, 1965-69; Board of Regents, ACP, 1970 to the present; Secretary General, ACP, 1974; specialty in hematology; M.D. degree from Harvard Medical School in 1937.



EUGENE P. DiMAGNO, M.D.
Rochester, Minn.

Assistant Professor of Medicine, Mayo School of Medicine, Rochester; Consultant in Gastroenterology and Internal Medicine, Mayo Clinic; full member, The American Gastroenterological Association; specialty in internal medicine and gastroenterology; M.D. degree from University of Pennsylvania in 1962.



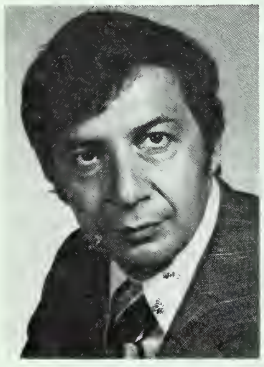
CHARLES M. JACOBS, J.D.
Chicago

Associate Director, Joint Commission on Accreditation of Hospitals, and Program Director, JCAH Professional Education Program; formerly a practicing lawyer; J.D. degree from the University of Chicago.



PHILIP B. MEAD, M.D.
Shelburne, Vt.

Assistant Professor, Department of Obstetrics and Gynecology, University of Vermont College of Medicine; specialty in obstetrics and gynecology; M.D. degree from Cornell University Medical School in 1963.



RUDOLPH P. GALASK, M.D.
Iowa City, Ia.

Associate Professor of Obstetrics and Gynecology and Associate Professor of Microbiology, State University of Iowa; membership in American College of Ob-Gyn, American Society of Microbiologists, Society for Experimental Biology ond Medicine; M.D. degree from Iowa Medical School in 1964.



HERMAN L. GARDNER, M.D.
Houston, Texos

Clinicol Professor of Obstetrics ond Gynecology, Boylor College of Medicine; Clinical Professor Gynecology, University of Texas Graduate School of Biological Sciences; president-elect, Internationol Society for Study of Vulvar Disease; specialty in gynecology; M.D. degree from University of Texas in 1937.

A financial contribution has been received from Merck Sharp & Dohme, A. H. Robins Company and The Upjohn Company to assist with the educational program.

Section on Obstetrics and Gynecology, Indiana Obstetrical and Gynecological Society and Indiana Chapter, American College of Obstetricians and Gynecologists

Room 203 Convention Center

8:30 a.m. Registration. Coffee and Rolls.
Moderator—William A. Karsell, M.D. Indianapolis

9:00 a.m. "AEROBIC INFECTIONS IN OBSTETRICS AND GYNECOLOGY," Philip B. Mead, M.D., Shelburne, Vt.

9:30 a.m. "ANAEROBIC INFECTION IN OBSTETRICS AND GYNECOLOGY," Rudolph Galask, M.D., Iowa City, Iowa

10:00 a.m. Time allowed to visit exhibits

10:30 a.m. "VIRAL INFECTIONS IN GYNECOLOGY AND OBSTETRICS," Herman L. Gardner, M.D., Houston, Texas

11:00 a.m. Panel Discussion — Questions and Answers
Philip B. Mead, M.D.
Rudolph Galask, M.D.
Herman L. Gardner, M.D.

12:00 noon Luncheon
View exhibits

Afternoon Session

Moderator—William A. Karsell, M.D., Indianapolis

1:30 p.m. "ANTIBIOTICS IN SEVERE OBSTETRIC AND GYNECOLOGIC INFECTION," Philip B. Mead, M.D., Shelburne, Vt.

2:00 p.m. "PROPHYLACTIC ANTIBIOTICS IN GYNECOLOGIC SURGERY, Rudolph Galask, M.D., Iowa City, Iowa

2:30 p.m. to 3:00 p.m. Time allowed to view exhibits

3:00 p.m. "MANAGEMENT OF VIRAL INFECTIONS IN OBSTETRICS AND GYNECOLOGY," Herman L. Gardner, M.D., Houston, Texas

3:30 p.m. Panel Discussion—Questions and Answers
Philip B. Mead, M.D.
Rudolph Galask, M.D.
Herman L. Gardner, M.D.

4:00 p.m. Business Meeting
Election of 1975 Section Officers



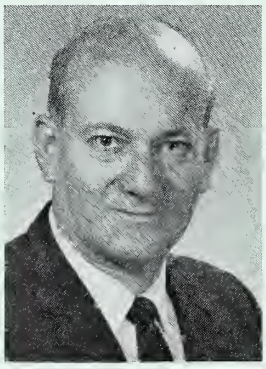
JORDAN FINK, M.D.
Madison, Wis.

Associate Professor of Medicine and Chief of Allergy Section, Medicol College of Wisconsin; certified, Americon Board of Internal Medicine, 1966, Allergy, 1967; M.D. degree, University af Wisconsin School of Medicine, 1959.

Section on Preventive Medicine and Public Health

Room 215 Convention Center

12 noon Luncheon. Robert M. Seibel, M.D., Nashville, Presiding
"LOCAL HEALTH DEPARTMENT COST STUDY ANALYSIS,"
Wilson L. Dalton, M.D., Shelbyville, chairman, Study Committee on Local Health Departments
Robert O. Yoho, H.S.D., Assistant Health Commissioner, Indiana State Board of Health
Business Meeting—Election of 1975 Section Officers



BENJAMIN BECKER, Ph.D.
Fort Wayne

Associate Professor, Purdue-Fort Woyne; Member, Sigmo Xi, Americon Chemical Society, American Saciety for Microbiolagy; specialty: chemistry and morphology of the order Actinomycetoles; graduate of Rutgers Institute of Microbiology in 1965.

Section on Allergy and Immunology

Room 218 Convention Center

1:00 p.m. "HYPERSENSITIVITY PNEUMONITIS, CLINICAL ASPECTS," Jordan N. Fink, M.D., Milwaukee

1:30 p.m. "BIOLOGY ASPECTS OF *ACTINOMYCETALES,*" Benjamin Becker, PhD., Ft. Wayne

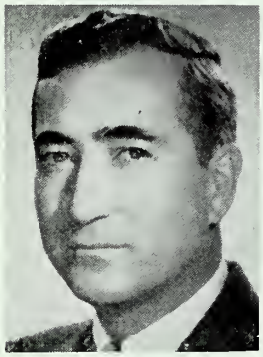
2:00 p.m. "ASPIRIN SENSITIVITY, NASAL POLYPS AND CYSTIC FIBROSIS," Irvin Caplin, M.D., Indianapolis

2:30 p.m. to 3:00 p.m. Time allowed to view exhibits



IRVIN CAPLIN, M.D.
Indionopolis

Associate Professor, Department af Pediatrics, I.U. School of Medicine, and Director of Allergy Clinic, Riley Hospital; diplomate, American Boord of Allergy and Immunology and American Boord of Clinical Immunology and Allergy; Fellow, Americon Academy of Allergy and American College of Allergy; M.D. degree from I.U. in 1939.



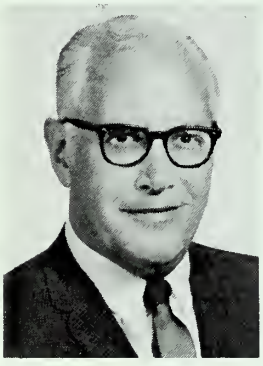
JAMES H. GOSMAN, M.D.
Indianapolis

Diplomate, Americon Board af Dermatology; Associote Professor of Dermatology, I.U. Medical Center; Postgraduate Medical Education Dept., Methodist Hospital; consultant, V.A. Hospital, Central State Hospital; M.D. degree from Indiana University School of Medicine in 1938.



DUANE D. HOUSER, M.D.
Indionopolis

Director, Immunology Educotion Service, Methodist Hospital; Fellow, American Acodemy of Allergy.



JULIAN R. KAUFMAN, M.D.
FORT WAYNE

Diplomote of Americon Board of Internal Medicine; diplomate, American Board of Allergy and Immunology; Fellow, American College of Physicians; Fellow, American College of Allergy; Fellow, American Academy of Allergy.

Place of Future Annual Conventions

1975—French Lick—October 18-23
1976—Indianapolis—October 9-14
1977—Indianapolis—October 10-14
1978—French Lick—October 14-19

THE EXHIBITS

We urge you to visit with the exhibitors—they are here to help you—and to bring you the latest information. They contribute to financing your convention.

Monday, October 7, 1974

3:00 p.m. "DIFFERENTIAL DIAGNOSIS OF ATOPIC DERMATITIS, James H. Gosman, M.D., Indianapolis

3:30 p.m. "PHARMACOLOGY OF THE BETA ADRENERGIC RECEPTOR SYSTEM," Duane D. Houser, M.D., Indianapolis

4:00 p.m. "IMMUNOLOGY OF MALIGNANCIES," Julian R. Kaufman, M.D., Fort Wayne

4:30 p.m. Business Meeting. Election of 1975 Section Officers

House of Delegates

4:00 p.m. House of Delegates Meeting, Room 210-211-212 Convention Center

Tuesday, October 8, 1974

Art and Hobby Show Mezzanine

8:00 a.m. Board of Trustees Breakfast, Room 226 Convention Center

8:30 a.m. Registration Continues

9:00 a.m. Opening of technical and scientific exhibits

9:00 a.m. to 4:30 p.m. **Practice Management Workshop** Rooms 202 and 203 Convention Center (See page 883 for complete program.)

"MEET THE PROFESSOR"

Rooms 215-216-220 Convention Center

These conferences will be conducted as informal, free discussion with questions from the physicians. Conferences will be held from 9:00 a.m. to 10:00 a.m. and 10:00 a.m. to 11:00 a.m. Registration will be limited to 20 physicians.

Room 215

"DIAGNOSIS AND TREATMENT OF THROMBOEMBOLIC DISORDERS," Walter D. Daly, M.D., Professor and Chairman of Department of Medicine, Indiana University School of Medicine, Indianapolis

Room 216

"DIAGNOSIS AND TREATMENT OF HYPERTENSION," C. E. Grim, M.D., Associate Professor of Medicine, Indiana University School of Medicine, Indianapolis

Room 220

"OBSTETRICS AND OFFICE GYNECOLOGY," Charles Hunter, M.D., Professor and Chairman of Department of Obstetrics and Gynecology, Indiana University School of Medicine, Indianapolis

Tuesday, October 8, 1974

Section on Directors of Medical Education and Association of Indiana Directors of Medical Education

Room 227 Convention Center

10:30 a.m. Business Meeting

12:30 p.m. Lunch—Dutch Treat

Afternoon Session

St. Vincent Hospital
2001 West 86th Street

2:00 p.m. Tour of Audio-Visual Department
Seminar on Audio-Visual Aids—Paul F. Muller, M.D., Indianapolis

Section on Anesthesiology and Indiana Society of Anesthesiologists

Room 225 Convention Center

12 noon Luncheon
"NITROPRUSSIDE FOR CONTROL OF BLOOD PRESSURE," Robert K. Stoelting, M.D., Indianapolis

Section on Urology and Indiana State Urology Association

Room 226 Convention Center

The program will be in two parts—The Fort Wayne Section of Urology will supply three speakers to be announced later.

John P. Donohue, M.D., Indianapolis—Moderator

1:00 p.m. "NEWER ADVANCES IN THE USE OF BOWEL IN UROLOGY," Arnold Melman, M.D., Indianapolis

1:30 p.m. "URETERAL MANAGEMENT IN TRANSPLANTATION," Michael Hostetter, M.D., Indianapolis

2:00 p.m. "ULTRASOUND IN UROLOGY," Frederick Goulding, M.D., Indianapolis

2:30 p.m. to 3:00 p.m. Time allowed to visit exhibits

3:00 p.m. "CLINICAL PROBLEMS OF PRACTICAL INTEREST," (Speakers to be announced.) David P. Schlueter, M.D., Fort Wayne—Moderator

4:00 p.m. Discussion

4:30 p.m. Business Meeting. Election of 1975 Section Officers.

Final Meeting House of Delegates

2:00 p.m Final Meeting of the House of Delegates, Rooms 210-211-212 Convention Center [Organizational Meetings of Board of Trustees and Executive Committee immediately following adjournment of the House of Delegates.]

Resolutions

(See also pages 869 and 881)

Resolution No. 74-7

Introduced by: Clark County Medical Society

Subject: DISASSOCIATION WITH AMA

Whereas, The 1973 House of Delegates of ISMA at their convention voted unanimously to oppose the concept of PSRO and to work diligently for repeal of PL 92-603 and its PSRO provisions; and

Whereas, At least 19 other state associations had committed themselves in like manner; and

Whereas, These associations had pledged delegates at the June 1974 meeting of the AMA Delegates in Chicago; and

Whereas, The AMA leadership was aware of this fact as well as the fact that at least 99 congressmen were prepared to introduce legislation for the repeal of PSRO; and

Whereas, It has become known that AMA lobbyists were actively working to oppose repeal of PSRO; and

Whereas, Through what appears to have been political maneuvering by the leadership of AMA, debate from the floor on the issue of PSRO prior to voting was closed at the June 1974 meeting of the AMA House of Delegates in Chicago; therefore, be it

Resolved, That, until such time as the AMA leadership shows more respect and consideration for the wishes of its member state associations and its individual members, the ISMA *actively* pursue aligning itself with whatever other medical organization will best represent the views and interests of the individual physician.

Resolution No. 74-8

Introduced by: Clark County Medical Society

Subject: REPEAL OF PUBLIC LAW 92-603

Whereas, The House of Delegates at the 1973 Indiana State Medical Association Convention voted unanimously to oppose the concept of PSRO and to work diligently for repeal of PL 92-603 and its PSRO provisions; and

Whereas, The wishes of this House of Delegates was made known to the American Medical Association, and

Whereas, At the AMA Convention of Delegates in Chicago in June 1974, the AMA House of Delegates, without the benefit of debate from the floor, elected *not* to work for repeal of PL 92-603; therefore, be it

Resolved, That the ISMA House of Delegates go on record as opposing the action of the AMA House of Delegates concerning PSRO legislation, since cooperation with bad legislation does not make it good legislation nor in the best interests of good patient care; be it further

Resolved, That the ISMA House of Delegates adopt to continue to oppose the concept of PSRO and therefore to urge and work for repeal of PL 92-603; be it further

Resolved, That the ISMA Board of Trustees be urged to continue to work for repeal of PL 92-603.

Program — Woman's Auxiliary to the Indiana State Medical Association

President—Mrs. Otis R. Bowen, Indianapolis

General Chairman of Women's Activities—Mrs. James L. Stribling, Columbus

Co-Chairmen of Women's Activities—Mrs. B. L. Weisenberger and Mrs. Floyd W. Mohler, Columbus

Chairman of Art and Hobby Show—Mrs. Harry Siderys, Indianapolis

Oktoberfest—Mrs. B. L. Weisenberger, Columbus

Indianapolis Museum of Art Luncheon Tour—Mrs. Floyd W. Mohler, Columbus

Reservations—Mrs. Shaffer B. Berkshire Jr., Columbus

Friday, October 4, 1974

9:00 a.m. Registration, Indianapolis Hilton

10:00 a.m. Open Executive Board Meeting, Woman's Auxiliary to the Indiana State Medical Association, Indianapolis Hilton

12 noon IMPAC Luncheon, Indianapolis Hilton
Speaker: Arthur R. Miller, LL.B, Professor of Law, Harvard University, "CONFIDENTIALITY OF MEDICAL CARE—CAN IT BE EFFECTIVELY PRESERVED?"

10:00 a.m. Tennis Tournament, Highland Golf and Country Club, 1050 W. 52nd St.
(See page 846 for details)

2:00 p.m. to 4:00 p.m. Workshop: "Idea Swap-Shop"

Saturday, October 5, 1974

10:30 a.m. Buses will leave the Hilton Hotel for the Football Game—I.U. vs. W. Va.—Bloomington, returning to Athenaeum, 401 E. Michigan Street, for the Oktoberfest.

6:30 p.m. Social Hour (Cash Bar) Athenaeum

7:30 p.m. Oktoberfest, Athenaeum. Dinner, Entertainment and Dancing.

Sunday, October 6, 1974

Art and Hobby Show, Convention Center

9:00 a.m. Registration Continues

12 noon Church service, Room 201, Convention Center
Speaker: The Reverend William B. Hudnut, Congressman

12:15 p.m. Buffet luncheon, Rooms 202-203-204

General Scientific Meeting

Honoring the 50th Anniversary of the Riley Hospital for Children

Convention Center

(Sponsored jointly by ISMA and Riley Memorial Association. Open to all physicians, their wives and guests.)

2:00 p.m. "CHILD ABUSE: ITS IMPACT ON SOCIETY," Brandt F. Steele, M.D., Denver, Colo.

2:30 p.m. "RECENT ADVANCES IN CHILDHOOD CANCER," Robert L. Baehner, M.D., Indianapolis
Jay L. Grosfield, M.D., Indianapolis

3:00 p.m. to 3:30 p.m. Time Allowed to View Exhibits

3:30 p.m. "RECENT ADVANCES IN PEDIATRIC GASTROENTEROLOGY," Joseph F. Fitzgerald, M.D., Indianapolis

4:00 p.m. "RECENT ADVANCES IN PERINATOLOGY," Edwin L. Gresham, M.D., Indianapolis

6:15 p.m. Reception Fifty-Year Club, Columbia Club

6:45 p.m. President's Reception, Columbia Club

7:30 p.m. President's Dinner, Columbia Club
Speaker: Alvin Toffler

Monday, October 7, 1974

Art and Hobby Show, Convention Center

9:00 a.m. Registration Continues

12 noon Luncheon, Garden Room Pavilion Restaurant, Indianapolis Museum of Art, 1200 W. 38th Street, Indianapolis

2:00 p.m. Private Tour of Indianapolis Museum of Art

Tuesday, October 8, 1974

Free Day

Report of Officers

Executive Secretary

In accordance with the directive of the House of Delegates and the Constitution and Bylaws, your secretary lists herewith the disposition of actions taken by the 1973 Meeting of the House of Delegates, Indiana State Medical Association.

The Printed Report of the President called for the review of the structure of the committees and commissions with the recommendation that it be referred to the Commission on Constitution and Bylaws, as well as the Commission on Special Activities, with an intent of a joint meeting later to work out changes if this be their conclusion.

Action: This has been actively pursued by a subcommittee of the Special Activities Commission, under the chairmanship of Dr. Hovda of Evansville. The Commission has not yet finalized its report, nor met with the Commission on Constitution and Bylaws.

Report of the Executive Secretary. The continuing disparity between expenditures and receipts of the Annual Convention was referred to Future Planning Committee for study and solution.

Action: The Committee discussed the Annual Convention and the loss of funds from lack of interest by exhibitors. Dr. Haley pointed out that the Indiana Academy of Family Practice annually held a very successful meeting, and this was confirmed by Dr. Petrich. The idea was suggested that the IAFP and ISMA consider joining together for their state convention. It was pointed out that the IAFP separates its business sessions from the scientific meetings, and it was generally expressed that this was worthwhile. The Committee urged that contact be made with the Executive Secretary of the IAFP to get reactions to such a proposal, and this recommendation be brought before the Board of Trustees and the Commission on Convention Arrangements.

The President has discussed this with the secretary of the Academy of Family Physicians, and it was agreed that each would appoint a committee of three to discuss this matter. No decision has been made as of this time.

Report of 11th Trustee District: James A. Harshman, M.D., Trustee. The item on unequal distribution of primary care physicians as related to specialty and subspecialty physicians was referred to the Commission on Medical Education and Licensure.

Action: Dr. Beering pointed out that inasmuch as the Rural Health Committee of the Commission on Special Activities has established an assessment committee to assess the needs of rural areas, the action of the Commission should be to (a) recognize this effort on the part of the Commission on Special Activities, and (b) ask that this Trustee report be heard additionally by them. The committee took this by mutual consent. Further, Dr. Beering has referred the trustee report to the Department of Community Health Sciences of the I.U. School of Medicine. A copy of this portion of the minutes of this Commission was given to the Commission on Special Activities.

Resolutions:

73-1. Re declaration of non-participation policy. Adopted by the House and called for notifying the HEW officials that our membership be encouraged not to participate in PSRO activities. Such a communication has been sent.

73-2. Prevention of advertising in the media by all so-called members of the healing arts.

Action: This was referred to the Commission on Legislation, which drafted legislation but was unsuccessful in getting it through the last session of the General Assembly.

73-3. Calling for the establishment of an ISMA Section on Allergy.

Action: The House adopted this, and a change has been made in the Bylaws to carry this out.

73-4. Calling for a special reference committee. It was adopted by the House as amended.

Action: This resolution has been referred to the officers of the Association for their review and action.

73-5. Additional ISMA staff members. Adopted by the House and referred to the Board of Trustees for implementation for the monies to do so.

Action: A part-time director for this division has been selected and is currently at work.

73-7. House Staff Membership, which was adopted by the House as amended.

Action: This matter has been referred to the Board of Trustees, which established dues for membership, and to the Commission on Constitution and Bylaws for appropriate changes in the Constitution and Bylaws.

73-8. Annual Meeting of Educational Program. Adopted by the House.

Action: This has been referred to the Commission on Convention Arrangements, which has met with the Commission on Medical Education and Licensure, as well as other specialty groups who are planning the 1974 program.

73-10. Legislation to Define the Word "Physician." Adopted by the House.

Action: This was referred to the Commission on Legislation, which prepared legislation, but was not able to find a sponsor to carry this in the state legislature the past year.

73-11. House of Delegates Meetings. Referred by the House to Future Planning Committee.

Action: The Future Planning Committee voted to oppose the concept of two meetings a year. The motion was seconded and the motion passed and Dr. Glock then moved that, at the next meeting of the House, the delegation be polled with the recommendation that the ISMA continue with the regular fall meeting but that a poll be an opinion survey on a one-day meeting in the spring to consider urgent matters which have accumulated, legislative issues, new resolutions, etc. This motion was carried. It is assumed that this Committee will arrange to take such a poll at the 1974 meeting.

73-13. Prescription Labeling. Adopted as amended.

Action: This has been referred to the Commission on Legislation, and negotiations have been undertaken with the Pharmaceutical Association.

73-14. Correlation of Medicaid and Medicare Regulations and Provider Payments. Adopted by the House as amended.

Action: No action has been taken on this resolution as of this time.

73-15. Physician Advisors to the Indiana Society of the American Association of Medical Assistants. This was adopted by the House.

Action: This has been placed into effect. The American Association of Medical Assistants has named its advisors, and the Executive Committee has filled the one spot of the Indiana State Medical Association by naming Dr. Donald M. Kerr, Chairman of the Executive Committee, as our representative on their Advisory Committee.

73-16. Support of Indiana Academy of Family Physicians attempt to obtain funds through the state legislature for development of new family practice residency positions. The House adopted this and amended the report.

Action: This was referred to the Commission on Legislation, which worked with Indiana University officials on legislation in the recent session of the General Assembly.

73-17. Retirement Membership. The House adopted and amended the report for this to be voted on by the House at the 1974 Annual Meeting.

73-18. Creation of Section on Urology. Adopted by the House and such a section has been added to the Bylaws of the Association.

73-19. Opposing the Quality Assurance Program for Medical Care in the Hospital as Proposed by the American Hospital Association. This was adopted by the House with recommendation that the Public Information Commission give adequate publicity as to why this program is opposed and so it will not be construed as against good quality of care.

Action: No action has been taken on this resolution by the Commission on Public Information at this time.

73-20. Concerning State Highway Commission. Adopted as amended. Referred to Commission on Emergency

Medical Services for their study with the recommendation that consideration be given the suggestion that a physician serve in an advisory capacity on the State Highway Commission.

Action: The Commission discussed Resolution 73-20 recommending that a physician serve in an advisory capacity on the State Highway Commission. They endorsed the concept but took no action on the matter.

73-21. Subject—Involvement in PSRO. Adopted by the House as amended. The Resolution called for an alternative of means of Peer Review and Quality Control without government control, and permitted the Indiana State Medical Association to establish an independent corporation. This was referred to the Board of Trustees.

Action: The Board of Trustees authorized the President to appoint a committee to begin work in establishing such an organization, and Dr. Dukes appointed Dr. Peter R. Petrich of Attica, as chairman, Dr. Dukes, Dr. Wilhelmus and Dr. Santare as the other members of the committee. The Board of Trustees at the June meeting had the presentation of the proposed articles of incorporation. However, that has not been finalized as of this date.

73-22. Establishment of a For-Profit Corporation on Malpractice Insurance. Adopted by the House of Delegates.

Action: This was referred to the Board of Trustees, which, in consultation with the Commission on Medical Economics and Insurance, and with the Harland organization, decided the first thing to be done was to make a survey of the membership to see if there was sufficient interest to warrant proceeding with this program.

The survey has been made and will be reported to the House of Delegates. A committee has been established with Dr. Donald M. Kerr of Bedford as chairman, the balance of the committee consisting of Dr. Dukes, Dr. Wilhelmus and Dr. Santare for the purpose of drawing up articles of incorporation for this project.

75-23. Increase in Dues. Adopted by the House as amended, which increased the dues of the Association 10.00 per year as of January 1, 1974, for use of the Commission on Public Information.

This concludes the report of the actions taken by the House and what actions have been taken on these referrals.

MEMBERSHIP REPORT:

Membership Records are Being Shattered

Is it the feeling of unity that is beginning to have its effect? Is it the Indiana Education Program? In any event, membership growth in both the ISMA and AMA for the first six months of 1974 has broken all records while the number of ISMA members not joining the AMA has shown a slight decrease over the last two years. We still need to find some way to get 327 ISMA members to reassess their reasons for not joining the AMA.

ANALYSIS OF MEMBERSHIP
TREND OVER PAST 10 YEARS

Year	ISMA 7/31	Gain Loss	AMA 7/31	Gain Loss	ISMA Members Non-AMA Members
1965	4356	+25	4255	+30	101
1966	4367	−11	4254	− 1	113
1967	4356	−11	4180	−26	176
1968	4400	+44	4246	+66	154
1969	4450	+50	4301	+55	149
1970	4457	+ 7	4291	−10	166
1971	4489	+32	4236	−55	253
1972	4526	+37	4179	−57	347
1973	4625	+99	4292	+113	333
1974	4743	+118	4416	+124	327

CHAMPUS:

For the period from October 1, 1973, to June 30, 1974, the CHAMPUS Department has processed and paid 15,545 claims, with a total dollar value of $1,311,604.84.

The CHAMPUS Department is again commended by the Department of Defense for its splendid work and the fact that their backlog of claims is lower than the national average, and lower than the goal of the Defense Department. The Indiana program is averaging about between four and five days backlog on claims.

We have been summoned to a meeting in Denver in September to have explained to us the changes which will take place in the CHAMPUS program in the next few months. It seems as though at the present time, from the information that we have, that many of the services, previously offered under CHAMPUS will be discontinued or drastically curtailed.

TEL-MED:

The success of the Tel-Med program is almost unbelievable. Letters are being received daily from people throughout the state of Indiana praising the physicians for making this service available to them. With the program beginning in March of 1973 and ending in May of 1974, with only one unit receiving local calls, a total of 70,845 tapes were played. We began the statewide system on May 22, 1974, in which we now have ten WATS lines available free of charge to people throughout the state of Indiana, and 10 local lines to the Indianapolis free calling area. For the period of 33 days from May 22 to June 29, the local lines have recorded 10,535 tapes played, the WATS line has recorded 19,210, for a total for both units for this short period of 33 days of 29,745 tapes which have been listened to by your patients. The total of the entire program, from March 1973 up through June 29, 1974, shows that we have played a total of 100,590 tapes for the people of the state of Indiana.

Our average calls per day are now running 901, with the largest single day we had totaling 1,097 calls. From the letters and cards received, I believe the Association should really consider this one of their best public relations programs in the past several years.

USE OF THE BUILDING:

The use of the building is not decreasing, but rather increasing as time goes on. The building is normally having meetings during the week, as well as on weekends.

Currently, the building is at capacity usage with the current staff and space for necessary mechanical equipment to conduct the affairs of the Association.

At the present time employees are practically sitting on each others' laps, and the aisleways of the offices are full of supplies and materials which have to be stored before being sent out to the membership of the Association.

The Board and the Building Committee have under study plans for possible expansion of the building, and I am sure there will be a report made to the House by the Board and by the Building Committee for their consideration.

ACTIVITIES OF THE VARIOUS COMMITTEES AND COMMISSIONS:

I will not attempt to detail the activities of the various committees and commissions of the Association, as these matters have been published in THE JOURNAL and widely distributed for information of the county society officers.

The activities of these groups are covered in their annual reports to the House, and I would urge you to read them to familiarize yourself with the activities that have been taking place during the past year. The commissions and committees have been unusually active, and I believe they have produced some good recommendations for consideration by the Association.

WHAT'S AHEAD?

Plans are under way, of course, to establish a not-for-profit corporation to do Peer Review and Quality Control, without government interference. This activity and the activity of PSRO in this

state is going to be a major problem, in my opinion, for the Association in the coming months and year. With the action of the House of Delegates urging our members not to participate in PSRO activities, and with the feeling of the House that we should establish an independent organization, plans are proceeding to develop this particular type of corporation, which is going to be expensive in development and operation. Dr. Petrich, a past president of the Association, is chairing the committee to set this up, and I am sure will have some report and recommendation for the House of Delegates to consider at this particular meeting.

A for-profit corporation for malpractice insurance is fast becoming a reality. A survey has been conducted by the Commission on Medical Economics to determine the interest of the membership of the Association getting into this activity. The poll has produced thousands of cards, which have not been tabulated, but it is hoped to have them tabulated and a definite program ready for offering to the House at this meeting.

The plan copied after that of Florida, if successful here as it apparently is in Florida, should be a great boon to the Association. We are informed that the first year of operation of the Florida plan produced a profit to the Florida Medical Association of some $100,000. If this could come to realization in the state of Indiana, it would certainly help conduct the affairs of the Association without additional increase in dues.

In the coming months and years, the legislative activity is bound to increase, and probably litigation also will increase, necessitating a good staff of legal counsel and headquarters staff to handle these particular problems.

The Continuing Education program is off to a good start, and it looks like it will be a very successful program for the Association. It is evident that, if the program continues to grow, the operation of it will require the full time services of a Continuing Education Director.

Inflation has hit your Association the same as it has in your personal practice, and your private lives. The finance committee of the Board of Trustees has undertaken at the time of this writing, a study of the financial position.

I express my appreciation to the staff for their loyalty and dedication to their responsibilities during the past year, and to the various Committees and Commissions, Executive Committee, and the Board of Trustees for their helpfulness and understanding of the problems facing this Association.

Your Headquarters Office is established to serve you and to look after your interests, and we welcome any suggestions from any member at any time we can be of service to you.

JAMES A. WAGGENER,
Executive Secretary

Treasurer

The audit for the fiscal year ended September 30, 1973, was published in detial in the January 1974 *Journal*. Inasmuch as the current fiscal year ends September 30, 1974, the audit will not be available for presentation to the House at this time. A current, detailed financial statement will be prepared by

INDIANA STATE MEDICAL ASSOCIATION
Statement of Financial Condition

ASSETS	6/30/74	9/30/73
GENERAL FUND:		
Cash on deposit	$ 81,871.34	$ 87,522.85
Investments—at cost:		
U.S. Treasury Bonds—long term	55,167.37	55,167.37
U.S. Treasury Bills—short term	300,573.94	179,829.30
Mutual Fund shares	31,799.78	31,038.50
Accounts receivable:		
Federal Grants	33,894.65	7,038.46
Other	14,479.10	17,961.24
Prepaid expense	14,093.58	12,070.72
Office furniture and equipment—net of accumulated depreciation	17,393.85	19,845.68
	549,273.61	410,474.12
BUILDING FUND:		
Cash on deposit	4,635.72	4,142.28
Cash in savings account	7,121.03	6,937.74
U.S. Treasury Bills	189,419.93	159,857.92
Prepaid expense	1,365.49	865.88
Accounts receivable	1,425.01	—
Headquarters property		
Land	69,187.60	69,187.60
Office building and improvements—net of accumulated depreciation	246,471.39	252,769.54
Rental properties—net of accumulated depreciation	77,396.52	78,829.32
	597,022.69	572,590.28
STUDENT LOAN FUND:		
Cash in savings account	19,190.00	19,190.00
Certificates of deposit	20,810.00	20,810.00
	40,000.00	40,000.00
MEDICAL DEFENSE FUND:		
Cash on deposit	930.60	807.60
Cash in savings account	23,826.36	22,021.46
U.S. Treasury Bonds—long term	25,526.53	25,323.40
Accounts receivable from General Fund	720.15	—
	51,003.64	48,152.46
	$1,237,299.94	$1,071,216.86

LIABILITIES AND FUND BALANCES

GENERAL FUND:		
Accounts payable	$ 18,978.95	$ 5,347.47
Payroll taxes withheld	—	1,689.34
Accrued taxes	—	308.21
Due to Medical Defense Fund	720.15	—
Dues payable to AMERF	20,420.00	20,407.50
Advances from AMA	9,277.81	9,277.81
Unearned portion of current year dues	215,572.50	107,692.13
Dues restricted to Speaker's Bureau	40,840.00	—
Exhibitors' deposits for annual meeting	365.00	13,920.00
Fund Balance	243,099.20	251,831.66
	549,273.61	410,474.12
BUILDING FUND:		
Accrued taxes on rental properties	3,324.97	2,857.43
Damage deposits and accounts payable	706.25	706.25
Loans from Members (non-interest bearing)	20,325.00	20,825.00
Fund balance	572,666.47	548,201.60
	597,022.69	572,590.28
STUDENT LOAN FUND:		
Fund balance	40,000.00	40,000.00
	40,000.00	40,000.00
MEDICAL DEFENSE FUND:		
Fund Balance	51,003.64	48,152.46
	51,003.64	48,152.46
	$1,237,299.94	$1,071,216.86

the Association bookkeeper and made available to the reference committee prior to the October meeting.

The accompanying report is a Statement of Financial Condition as of June 30, 1974, compared to the audited financial statement of September 30, 1973, as published in the January 1974 *Journal.*

HUGH K. THATCHER, JR., M.D.
Treasurer

Chairman of the Board

During the past year the Board of Trustees met several times to discuss a multitude of matters. The volume of business of the Board has currently reached such proportions that it is now routine for the Board to meet both on Saturday evenings and all day on Sundays to discuss each subject in proper detail and in depth.

During the year the complete minutes of each trustee meeting were printed in THE JOURNAL of the Indiana State Medical Association, and a highlight summary of each meeting was sent to presidents and secretaries of county medical societies, ISMA delegates and alternate delegates, AMA delegates and alternate delegates, and executive secretaries of county medical societies.

However, for the purpose of this report I will summarize briefly for the membership some of the actions of the Board during this past year. This does not constitute a complete summary of the numerous speakers who appeared before us to relate matters of concern to our members or a complete listing of all of the actions of the Board.

The Future Planning Committee was asked to study and report back on the Allen County Medical Society's proposal for changing meetings of the House of Delegates to more effectively coordinate activities of the Association with legislative programs. Locations for future conventions of the Association as currently projected are 1974—Indianapolis; 1975—French Lick; 1976 and 1977—Indianapolis; and 1978—French Lick.

The membership dues for students was given consideration by the Board as an outgrowth of House of Delegates' action to grant memberships to students. The Board referred the matter to the Commission on Constitution and Bylaws with the request that they consider such dues and report back to the Board. Since this action is a constitutional one, final action on the matter is to be taken at this (1974) meeting of the House.

The new Medical Practice Act and its introduction into 1974 legislature received lengthy discussion. Final outcome of the pro and con discussion was that the legislation will not be introduced this year but that an amendment to the current Act be introduced to give the Board of Medical Registration and Examination the power to suspend a physician's license pending review by the courts. Board felt that there was too much strong opposition to the new Medical Practice Act by physicians to proceed with the introduction of the Act at this time. It was also expressed that time for presentation of the legislation in 1974 was too limited and that it should be revised for presentation in 1975.

The continuing education accreditation program received up to $10,000 to conduct this program. The Board asked the chairman of the Commission on Medical Education and Licensure to appear to explain specifically how the money would be utilized through the addition of a staff person to oversee this program.

A proposed emergency medical services bill was reviewed by the Board and was referred to the Commission on Legislation for implementation through the legislature.

Family Practice residency programs for Indiana were also reviewed and recommendation was made that a bill be introduced by the Commission on Legislation concerning development of such programs.

In other actions dealing with legislative matters, the introduction of a "Death with Dignity" bill was moved but was not introduced because of the lack of a second to the motion. Last year's attempt to introduce a similar bill met with no action because legislators did not want to sponsor such a bill.

The rejection of QAP and TAP programs called for in a resolution was adopted by the Board. ISMA delegates to the AMA were instructed to introduce a resolution to the AMA House of Delegates at Anaheim. The resolution stated that quality of care is the proper function of the physician through his medical society and hospital staff and that the

two programs involve great expense and non-physician review. QAP is the Quality Assurance Program of the American Hospital Association. TAP is the Trustee-Administrator-Physician Program of the Joint Commission on Accreditation.

In response to the PSRO resolution adopted by the House of Delegates, the Board considered the following questions on establishing an independent corporation to accomplish peer review and quality control in medical care: what type of organization should be established; what will its function be and how will it be funded? After lengthy discussion, the Board adopted a motion to proceed with the organization of a non-profit corporation with the advice of the legal counsel of ISMA.

Members of the Board were asked to contact Congressmen personally on objections to PSRO and stand of ISMA. The Board also passed a motion that a letter be sent to every Indiana Congressman advising them of ISMA action on PSRO with a note that they would be contacted by a trustee.

A policy of no contracts with proprietary hospitals by Blue Cross was asked to be withdrawn by the ISMA Board of Trustees. In a resolution, the Board pointed out that more and more communities are finding themselves in a "position where it is impossible, because of present tax burdens to make the necessary improvements or replacements as required by the State Board of Health and that one of the most pressing needs in Indiana is to improve the quality of medical care in smaller communities, and the best way to do it is to improve facilities so that new doctors will be attracted to those communities." The resolution asks that proprietary hospital plans and development in communities be judged on individual merit by Blue Cross.

The establishment of a for-profit corporation to set up a professional liability program for members of the ISMA was given the go-ahead by the Board. In addition, a survey will be made of the membership to determine interest of members in the program. Investigation by the Commission on Medical Economics and Insurance through the past year has shown such programs are working to the benefit of the association and its membership. The corporate bylaws will be reported back to the Board for approval before additional procedures take place. Board authorized up to $1,000 to accomplish these preparatory steps.

Plans went on the drawing board for expansion of the ISMA headquarters by action of the Board. Week-long use of the building by the membership and allied health and medical groups, lack of parking space, lack of necessary office space, lack of storage space and anticipation of future needs for the Association are some of the reasons for expansion plans. Potentiality of holding House of Delegates' meetings in the new headquarters is a real possibility with accompanying lesser costs. Board authorized up to $15,000 for architectural fees, drawings, etc.

The Joint Practice Committee of Nurses and Physicians was granted $1,000 by the Board in a one-time grant to initiate activity of the committee. The Board heard Dr. G. J. Rosenberg report on the planned activity of the committee which is concerned with the congruent roles of nurses and physicians in new patterns of medical practice. The Indiana Nurses Association has also allocated $1,000 to the joint committee. Forty-six states now have such committees. The physician-members are to be nominated by the ISMA and their policies are to be approved by both organizations.

The creation of an independent state university from the regional campus of Indiana-Purdue University, Indianapolis, was discussed at length. Motion was made and passed that the Board go on record opposing the Indiana University School of Medicine being a part of the new university and that legislators be so advised. The board further moved to send a letter to personal physicians of the legislators requesting them to contact their legislators.

Physicians were queried by health insurance carriers as to their medical judgment in utilizing types of injections for patients under Medicare. Specifically referred to was the use of B-12. The Board recommended that a letter be sent to the carriers objecting to clerks not only questioning but recommending treatment. Also discussed was the activity of the State Department of Public Welfare requesting physicians to submit plans for certain types of elective surgery to gain permission to operate. The Board voted that the language in the letter was totally unacceptable to the ISMA and that the Board's displeasure be conveyed to Blue Shield, the State Department of Public Welfare, and to The Travelers Insurance Company.

The promotion of a standard claim form for all health insurers was passed by the Board, and the Indiana Insurance Commissioner was approached on this matter.

Director of the Joint Commission on Accreditation of Hospitals, Dr. John D. Porterfield, reported to the Board on the commission's activities. The invitation came from Indiana because of commission inspectors leaving the impression that retrospective audit of physicians was to become mandatory and expected by the commission if a hospital was to be accredited. Dr. Porterfield clarified this for the Board and answered a multitude of questions concerning the commission's operation. He explained the history of the joint commission and the objective of the commission to develop standards and programs which would encourage medical staffs to be more involved in the quality of their work.

The rural assessment and assistance program formulated by the Commission on Special Activities was authorized by the Board to continue its progress and to seek funds from the Department of HEW. The major objective is to develop a suitable group of practicing physicians, physicians in training, other health providers and interested citizens, with an interest and experience in rural areas, to provide assessment and assistance in obtaining physicians, other medical personnel, and facilities for identified medically underserved areas.

Dr. Steven C. Beering, new dean of the I. U. School of Medicine and chairman of the ISMA Commission on Medical Education and Licensure, introduced Mr. Edward Raffensperger, new coordinator for the ISMA continuing medical education accreditation program. The dean pointed out to the Board that Memorial Hospital and St. Joseph's Hospital in South Bend; Deaconess Hospital, Evansville; St. Joseph's Memorial Hospital, Kokomo, and Reid Memorial Hospital, Richmond, have been accredited, with the LaPorte Hospital, LaPorte, currently being considered.

Tel-Med, the ISMA telephone health information service, was expanded to the entire state through an additional grant from Regional Medical Programs, a major contributor along with Eli Lilly and Company.

Comprehensive Health plans to fund a position in ISMA of a liaison representative to state and regional CHPs if the current program is extended and funded, Dr. Paynter, Commissioner of Health, reported.

A committee of the Special Activities Commission is making a study and evaluating the structure and activities of the committees and commissions of the ISMA. The Commission's recommendations will be forthcoming to the Board.

Copy and costs for a new insurance pamphlet entitled "You and Health Insurance" was presented to the Board by Dr. Kenneth J. Ahler, author of the pamphlet and member of the Commission on Public Information. The pamphlet gives the physician's viewpoint on health insurance and would be distributed to patients in doctors' waiting rooms. The Board approved the printing and distribution.

Referring to PSRO organizations across the nation as a "mixed bag," Dr. Donald Wood, AMA trustee, told the Board that the national board had taken a lot of criticism. At the moment, he said, there is a great surge for repeal. He cited, however, several states which were pro-repeal but while pushing for repeal were also seeking federal funds to establish a PSRO. AMA is in a difficult position as this type of bilaterial action occurs, he said. The AMA House

of Delegates, he said, would have to make a clear-cut policy.

The establishment of a PSRO support center by the ISMA was then discussed at length and the motion was made to apply for the center. The motion lost by a vote of nine to eight, a margin of one.

The establishment of a malpractice insurance program was reported to the Board. Florida representatives met with Dr. K. O. Neumann, chairman of the Commission on Medical Economics and Insurance, and planned a questionnaire to determine the interest of Indiana physicians. The Board moved that the survey be approved.

"Maintain the 55-mile-per-hour speed limit in Indiana," the Board stated in a motion, which passed. Observation was made that the lower speed limit had saved many lives and that even though the fuel shortage crisis had passed, the limit should continue because of the marked decrease in the highway toll.

Concerning the repeal of PSRO, the Board mandated the AMA delegation to work for and use its skill and resources to repeal PSRO and that a resolution be submitted asking for the AMA to take a positive stand for repeal.

The American Medical Association was urged by the Board to develop graphs, charts and other materials to illustrate the rise in physicians' fees in comparison with those of other professions.

Following the discussion of the Medical-Legal Defense Fund, the Board moved that monies collected in the fund be held and permitted to grow with eventual use in supporting legislation to change the existing Indiana laws concerning malpractice, and that the fund allow consultation between a physician and his attorney and the ISMA's legal counsel on questions not pertinent to malpractice defense and with the approval of the Executive Committee. The motion was based on a recommendation by the Medical-Legal Review Committee and will be forwarded to the House of Delegates for their consideration.

Feasibility of the Indiana Academy of Family Practice and the ISMA joining together in an annual convention was discussed by the Board. The Board moved to have three members of the Board meet with three members of the Academy Board to discuss possibilities.

A form issued by Mutual Hospital Insurance, Inc. and Mutual Medical Insurance, to be signed by the patient for authorization of disclosure and use of information in patient records and other similar forms, was discussed by the Board. The Board passed a motion directing the ISMA legal counsel to explore the advisability of instituting a suit against the intermediaries and continue to take action to stop the wholesale invasion of medical records in government programs.

The Statute of Limitations in Lake County malpractice suit was discussed by the Board. Lake County physicians were sued by a man who stated he had been injured at birth in the course of delivery. He filed suit just before his twenty-fourth birthday. The case was settled in the physicians' favor in Court of Appeals and overturned by the Supreme Court. The Board moved that legislation be drafted by ISMA attorneys to offset such future suits.

The Board heard a report that the physicians' assistants and nurse practitioners are a reality in Indiana. A proposed resolution to the House would include the following: (1) that they be graduates of certified programs, (2) that only one certified graduate be allowed to work for a doctor, (3) that they be under the direct supervision of a physician and all of this pertaining to medicine, (4) that they be allowed to work in the hospitals but will not be permitted to write orders for treatment to be made, unless countersigned by the doctor within 24 hours. The Board moved to forward the resolution to the House of Delegates.

Concerning the building program, the Board at its June meeting passed a motion to proceed with blueprint development for an additional 16,000 square feet of space and an alternative plan for 10,000 square feet, that contractual bids for the construction be taken and presented to the August meeting of the Board and then the final plan presented to the House of Delegates.

Progress of the Speakers' Bureau was reported to the Board. The speakers are to be handled by a special service which will book the speakers, evaluate audience reaction, handle publicity and all other details.

The Board is now reviewing the articles of incorporation of the Indiana Medical Education and Developmental Information Center, corporate name for the independent peer review organization, directed to be developed by the House of Delegates in 1973.

VINCENT J. SANTARE, M.D.
Chairman

First Trustee District



BERNARD B. ROSENBLATT, M.D.
Trustee

The First District Medical Society held its annual meeting on May 9, 1974, at the Rolling Hills Country Club, Evansville, which was well attended by physicians and their wives from throughout the district. Mead Johnson and Company hosted the social hour, and Mr. Tom Miller, new field service representative for Mead Johnson and Company, was introduced.

Other guests in attendance included Joe Dukes, M.D., president of ISMA, and Mr. Gary Miller, director of professional relations for Indiana Blue Shield.

Speaker for the evening was Mr. Wayne Bradley, assistant director of the Washington office of the American Medical Association. Mr. Bradley gave an extensive and extremely interesting report on the current state of federal legislation in the area of health care. He particularly emphasized those areas in which organized medicine has achieved success in recent months, including the successful attempt to fight pre-admission certification, the prevention of continuation of fee controls, the recent HEW decision that physician offices and clinics are not to be included in the national certificate-of-need legislation (Section 1122 of Public Law 92-603), and the recent upgrading of the Keogh Plan. Mr. Bradley mentioned that several polls show that the public does not currently give high priority to national health insurance.

Dr. Dukes brought greetings to the First District from the ISMA and reviewed state action in regard to PSRO. He stated that some of the concerns of the Board of Trustees are that PSRO will infringe on the patient's rights, create a loss of confidentiality and threaten individuality of treatment. In addition, he said that the program would create a bureaucracy and would duplicate existing peer review programs. He said, however, that there would be a state support center in Indiana developed by people close to medicine, and this group would act as a watchdog.

Because he had only recently joined the Blue Shield Board, Dr. Ralph Carlson asked Dr. Willard Barnhart, last previous Blue Shield Board member from the First District, to report on the current status of Indiana Blue Shield. Dr. Barnhart reported that Indiana Blue Shield is 8th in the nation in the amount of business transacted, and covers two million people. Unlike many other plans, Indiana Blue Shield has a sizeable financial reserve. In 1972 and again in 1973, utilization leveled off, and a rebate in the amount of $11 million the first year and $19 million in the second year was made to members. Blue Shield is presently returning 94 cents of each dollar of premium payment, which means that only 6 cents per premium dollar is spent for administration. Dr. Barnhart mentioned that this summer Blue Shield will offer an improved indemnity plan. These will be less costly than usual and customary contracts, and will range from 60 to 90% of the cost of usual and customary policies. He asked that physicians urge their patients to participate in Blue Shield plans.

Dr. William Dye, First District President, presided over elections of officers,

and the following persons were elected: Albert S. Ritz, M.D., president; Martin Bender, M.D., vice president; John Barrow, M.D., secretary-treasurer; Bernard B. Rosenblatt, M.D., trustee; DeVerre Gourieux, M.D., alternate trustee.

During the past year, the First District supported a reception and luncheon for ISMA officers, trustees, delegates and alternate delegates in honor of Gilbert Wilhelmus, M.D., candidate for president-elect of ISMA, and P.J.V. Corcoran, M.D., candidate for delegate to AMA. Both candidates were subsequently elected.

In order to maintain close liaison with the only staffed county medical society in the First District, the trustee is routinely invited to attend meetings of the Vanderburgh County Medical Society Board of Directors. Here, he reports on activities at the state level, and receives suggestions and information to take to the ISMA Board of Trustees. This arrangement has worked well for several years.

Among other actions originating in Vanderburgh County but of significance to the entire district this past year are:

1. A resolution calling for redefinition of the legal meaning of the term "physician" was sent to the House of Delegates, approved, and an attempt was made to seek state legislation embodying this change. The attempt failed, but will be repeated in the coming year.

2. The society has very nearly completed the updating of fee guidelines for all specialties for the purpose of guiding peer review.

3. A society membership roster which will include all First District physicians will be published in September 1974.

4. A standard health and accident insurance form was approved in Vanderburgh County and sent to the ISMA Board of Trustees with the suggestion that ISMA seek its approval by the State Insurance Commission. The matter is presently being considered by the Commission.

5. The Vanderburgh County Medical Society is cooperating with the three Evansville hospitals and the Area Health Planning Council in presentation of community health education forums each month during the fall and winter. These are on various disease entities, and the first two, on allergies and diabetes, were extremely well attended and well received.

6. At the request of the Area Health Planning Council, the Vanderburgh County Medical Society is evaluating the functioning of the new open heart surgical unit at Deaconess Hospital.

7. Area physicians cooperated with the Evansville Mayor's Energy Action Committee in preparing an estimate of the energy needs of the health care sector of the community.

8. The county medical society joined the First District in hosting a reception and luncheon to support the candidacies of Gilbert M. Wilhelmus, M.D. for ISMA president-elect and P.J.V. Corcoran, M.D. for AMA delegate.

9. The county society arranged for seven area physicians to appear on television in connection with various health programs.

It is rewarding to the trustee to see the high degree of cooperation among physicians throughout the First District and the leadership which our members show in so many areas. He wishes to thank them for their active participation and also for their support during the past year.

BERNARD B. ROSENBLATT, M.D.
Trustee

Second Trustee District



PAUL W. HOLTZMAN, M.D.
Trustee

During the past year, true representation of my district has become even more exasperating for I find the district divided in its goals and divided in its opinion of the ISMA and the AMA. It is difficult to be positive in my report, but there have been the usual poorly attended medical society and district meetings.

Progress made by the ISMA and the AMA is frequently overlooked. Criticism among the members comes easily, but constructive help is not offered. Our association is being divided by those who favor or oppose government interference. Those new to medicine entertain new philosophies concerning "the place of medicine" and further divide us. I have asked my own society, without avail, to introduce a resolution to the House of Delegates to allow the dues of ISMA to be increased in order that we could have more field representation and thus disseminate information more readily to practicing physicians. I find information regarding concepts, goals, and intentions of the ISMA and AMA widely misunderstood or poorly interpreted.

I believe our goal during the next year, should be directed toward union and somehow—someway—allowing all physicians in the state to know and understand the basic problems of medicine before they preform opinions and decisions not based on sound information.

Most of us physicians treat our ISMA like our investments—we ignore them, but raise hell when they fail to yield good results.

PAUL W. HOLTZMAN, M.D.
Trustee

Third Trustee District



ELI GOODMAN, M.D.
Trustee

The 1973 Annual Meeting of the Third District Medical Society was a combined meeting with Third District of the Indiana Academy of Family Practice.

The meeting was held at the Marriott Resort Center in Clarksville on Wednesday, Sept. 26, 1973. A good-sized delegation to represent the State Medical Association was headed by Dr. James Gosman, president.

District president, Dr. Claude J. Meyer, presided, and Dr. Robert K. McKecknie served as secretary.

Dr. Gosman gave a comprehensive and thorough report from his position as state association president. Dr. John Paris, district representative and vice president of Blue Shield, gave a report on the current relationship between Blue Cross and Blue Shield, and answered a number of questions from the floor.

Reports were made by the trustee and the alternate trustee. Much discussion took place about the apparent failure of Indiana AMA delegation to make our position of opposition to participation in PSRO-type activity perfectly clear at the AMA level. It was decided to bring this matter to the attention of the House of Delegates of the Indiana State Medical Association at its annual meeting in October 1973.

In other business, a resolution to increase district dues to $10 was unanimously passed. In election of officers, Dr. Claude J. Meyer was reelected District Chairman; Dr. Robert K. McKecknie was named District Secretary, and Dr. Eli Goodman was reelected District Trustee.

The after-dinner speaker was Dr. Pillows of the Eli Lilly Company. His topic was his work with youth and the drug program.

The 1974 annual meeting will be something new for the Third District in the form of a weekend to include lots of fun. Golf, tennis, swimming, boating and dancing are all on the agenda, along with three hours course credit by the Academy of Family Physicians.

This combined District ISMA-IAFP meeting will run from 1:00 p.m. Saturday, Sept. 14 through 1:00 p.m. Sunday, Sept. 15. It will be held at the fabulous Marriott Inn-Sports Center at Clarksville, where a floating bridal suite is available to young (or not so young) vigorous lovers at only $49 a day.

The scientific program "What Do You Say After You Say Hello?" will be of

equal interest to the wives as well as the doctors. Dr. and Mrs. Edgar Stuntz of Purdue will give this Wyeth Laboratory-sponsored program beginning at 3:00 p.m. Saturday afternoon.

There will be a dinner dance Saturday evening. A bloody-mary brunch on Sunday morning will be sponsored by Bonco Laboratory and informal discussions, swimming and other sports will round out the Sunday program.

Really, all I can say about this exciting program is "Y'all come."

I would like to conclude this so-far factual narrative annual report with some personal observations of great concern to me.

In my last report (1973) I indicated my great concern about the impact of PSRO on the nature of medical care of American people and on the effectiveness and life position of each and every physician along with it.

Since that time, as you all know, the ISMA has taken an official position opposed to PSRO and since I was present I can personally vouch that our AMA delegation reflected this position in their voting at the June 1974 AMA meeting in Chicago. However, as you all know by now, our position was not adopted and the AMA will try to make PSRO work while not consulting those individual states that elect to take different steps from this now official AMA policy.

I have always felt that the structure of the AMA is indeed democratic and we have heard the will of the majority and in our system we must abide by it.

I would, however, fault that House of Delegates of the AMA for one thing in the brief consideration of this vital issue of PSRO. There was an appeal for a roll-call vote which the House quickly squelched. I feel that each and every member of that June 1974 House of Delegates would have done organized medicine a great service by being willing to have his individual vote recorded, and I feel that the failure to do so was a disservice that might well contribute greatly to the additional fragmentation of organized medicine.

I hope that Indiana will be a leader in an effort to alter the mechanism so that a roll-call vote can be mandated in vital issues by a minority, so that the majority cannot again "cop-out" on such vital issues so easily. I make this appeal because I am fundamentally opposed to the fragmentation of the voice of medicine that some of our members as well as all of our opponents look forward to for various, if contradictory, reasons.

ELI GOODMAN, M.D.
Trustee

Fourth Trustee District



HOWARD JACKSON, M.D.
Trustee

The annual meeting of the Fourth District Medical Society was held at the Seymour Country Club, on Wednesday, June 12, 1974. Elections were held during the business meeting which began at 4:00 p.m.

Dr. A. A. Daftari, Batesville, was elected president. Dr. Robert Acher was elected vice president and Dr. Lanny Copeland of Osgood was elected secretary-treasurer. Dr. Howard Jackson was reelected trustee.

A lively discussion developed over PSRO, third party intervention, over the lack of communication among the physicians in the Fourth District and, in general, over the purpose and use of Fourth district dues money. It was determined by the delegates that fifty dollars ($50.00) per month would go to the trustee, in the interest of better communications among the physicians of the Fourth District. It was hoped that a form of newsletter could be developed and sent to each physician each month or at least after each Board of Trustee meeting.

The evening meeting was highlighted by the well received talk of Dr. Jose Oller. Dr. Oller is a New Orleans neurosurgeon and president of the Council of Medical Staffs. The substance of his talk was the basis for an article in the *Medical World News* of June 21, 1974. We learned a great deal from Dr. Oller's talk.

PSRO has become the most talked about issue in the medical community. It is predicted that PSRO will be the most divisive issue of our time. I believe this prediction is all too true. Much activity has been taken by several in the Fourth District, especially by Dr. Blaisdell, the alternate trustee, and by the Seymour Medical Society in an attempt to educate our patients and our legislators with the objective of repealing PSRO. Many feel that they will be unable to practice with these kind of punitive laws governing us. I hope that this activity will continue and will become more widespread in the Fourth District.

The Fourth District meeting in 1975 will be hosted by Ripley County at Batesville, Indiana. The date has not been determined as yet.

I want to thank all the physicians in the Fourth District for their cooperation, for their activity in the medical society and for their participation in the committees and commissions of ISMA.

HOWARD JACKSON, M.D.
Trustee

Fifth Trustee District



C. M. SCHAUWECKER, M.D.
Trustee

This has been a most productive year for the Fifth District. First, after six long years of trying to find some method of financing either an extensive remodeling program for the Putnam County Hospital, or building a new structure—and having absolutely no success—we were able to get a bill through the Indiana legislature that would allow proprietary hospitals to be built in Indiana and not be discriminated against by Blue Cross simply because they are proprietary in nature. We wish to make it perfectly clear that we are not suggesting that any other county follow this method, for we know that local financing and operation definitely have advantages. However, we do think it is important that those counties, like ours, who find themselves completely unable to finance the project by local taxes, now have another method to turn to. As this is being written, the ground has been purchased, and a survey team is at work. While much hard work on the part of the County Medical Society was primarily responsible, the fact that a new hospital is apparently going to be built in Greencastle certainly aided us greatly in recruiting two new family physicians who have begun practice here within the past month. One additional physician is planning on coming within the next one or two months, and another has agreed to come next July. It is our feeling that the combination of much hard work, by the local doctors, plus being able to offer the new prospective physician excellent facilities in which to practice, is the probable answer to getting new men to come to the outlying areas, and thus upgrade the practice of medicine in these areas.

A second most important event occurred, which was the instigating of an emergency ambulance system in conjunction with the Comprehensive Health Planning group in this area. This consists of Clay, Parke, Putnam, Sullivan, Vermillion and Vigo Counties (five of these counties make up the Fifth District). It is the goal of this group to have a well-equipped ambulance (one or more) in each of these counties and to have them manned by properly trained ambulance technicians 24 hours each day. The ambulance technicians, by means of two-way radio, will be in constant contact with the Emergency Room of St. Anthony's Hospital at Terre Haute, which is manned around the clock. They can also be in two-way contact with the

local hospital, and thus receive constant supervision while at the scene, or during transportation of the patient to the respective hospital. EKG monitoring will be available for those cases where it is required. It is hoped that this will be in operation by this fall. To the best of our knowledge, this will be the first such program in the U. S.—where the coverage will be on the basis of the Comprehensive Health Planning Area. The people of the area owe a great debt of gratitude to Dr. Wilbert McIntosh for the tremendous amount of effort he put into this project.

Our annual Fifth District Meeting occurred at Turkey Run State Park on May 22, 1974. President Frank Swaim of Rockville called the business meeting to order at 4:00 p.m. It was well attended, and Dr. George Crane, the columnist, gave a most interesting and informative talk on present legislation before congress and how physicians could influence this legislation much more if they would only take the time and effort and get involved.

The election of new officers for the Fifth District was then held and the following were elected:

President: Paul Humphrey, M.D., Terre Haute

Secretary-Treasurer: Fred Dierdorf, M.D., Terre Haute

Following the business meeting, dinner was served to approximately 70 members. The main speaker was Dr. Crane, who gave an informative yet humorous talk. The talk centered chiefly on the common causes as to why husbands and wives stray. He used some personal cases to illustrate the talk and stressed the importance of psychology in marriage. The talk was very well received.

Next year's meeting will be at Terre Haute, but at this time the date has not been set.

CLEON M. SCHAUWECKER, M.D.
Trustee

Sixth Trustee District



PAUL M. INLOW, M.D.
Trustee

The need for primary care physicians is being felt in the Sixth District. There is now a public health physician in Rush County.

I feel there is a great need for the ISMA to implement our own state malpractice insurance company. The number of insurance companies writing malpractice insurance has continued to decrease.

The Sixth District Medical Society's annual meeting was held on May 9, 1974, at the Connersville Country Club with Dr. J. H. Tower, Jr., president, presiding. The members of the various commissions of the Indiana State Medical Association from the Sixth District were recognized and gave brief reports of activities of their respective commissions. A report was then given by the trustee and alternate trustee.

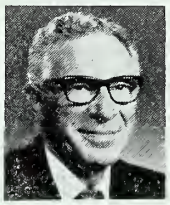
The Sixth District dues were raised to $5.00 a year.

The newly elected officers of the Sixth District are: President, Davis W. Ellis, Jr., M.D., Rushville; vice president, William Kerrigan, M.D., Connersville, and secretary-treasurer, Clarence Clarkson, M.D., Richmond.

Our evening speaker was David Crane, M.D., a Bloomington, Indiana, psychiatrist who discussed federal inroads into medicine and urged all physicians to continue their efforts to prevent such interference as much as possible.

PAUL M. INLOW, M.D.
Trustee

Seventh Trustee District



JOSEPH F. FERRARA, M.D.
Trustee

The Seventh District held its annual meeting on June 5, 1974, at the Speedway Motel, Indianapolis.

Golf was the order of the day and the prizes were won by Dr. John Records of Franklin and Dr. Ted Grissell of Indianapolis.

At the business meeting Dr. John Butler of Indianapolis was reelected trustee. Dr. Don McCallum of Indianapolis was reelected alternate trustee. Dr. John Records of Franklin was made president-elect and Dr. Malcolm Scamahorn of Pittsboro was reelected secretary-treasurer.

President of the Seventh District Medical Society for this year will be Dr. Ray D. Miller of Martinsville and of the Morgan County Medical Society. They will be the host for the 1975 meeting.

PSRO was the topic of discussion and it was quite apparent that most of those attending were for repeal of the law and not implementation. They were told that the ISMA Board of Trustees stood opposed and were for repeal. Dr. Scamahorn reported that our delegates to the AMA voted against PSRO and for repeal of the law and further stated this was the attitude of the AMA House of Delegates.

Our dinner speaker was David Crane of Bloomington, and *guess* what his subject was: PSRO. Dr. Crane suggested that we stimulate the public—the voters—to write to their congressmen, especially since this is an election year. He also suggested writing letters to the editors of newspapers and, when printed, sending the whole page to the congressmen. He mentioned that the law makes the HEW secretary a czar over medicine, and decisions on issues concerning doctors and the practice of medicine will be at the discretion of the HEW secretary.

Also, confidentiality of medical histories and reports was stressed. Confidentiality is already being destroyed and will get worse. There was mention of a case of a woman in California and in her medical history there was mention that at one time she was a prostitute. This went thru the computer and became public—as a result—a lawsuit.

We were told medical forms at present are being standardized for computerization and it was mentioned that Federal Bureaus have called up I.R.S. tax returns which are supposed to be confidential.

So what can happen to medical reports?

There was a very hot and lively discussion from the audience concerning PSRO and the tenor was for repeal of the law—not implementation.

Also, there was a definite feeling that the AMA was not representing the doctors' stand for repeal.

At any rate, I believe everyone present was convinced that Johnson County was for repeal of the law and not implementation.

This has been a trying year on the Board what with the government's interference in medicine in many various ways and all that we, as doctors, have to do is be divided and we will be conquered.

One thing for sure—a representative or trustee sure can't please everybody he represents.

JOSEPH F. FERRARA, M.D.
Trustee

Eighth Trustee District



RICHARD INGRAM, M.D.
Trustee

The annual meeting of the Eighth

Medical District was held at the Anderson Country Club on May 29, 1974. There was golf in the afternoon for those interested. In the evening there was a business meeting.

Interesting highlights of the business meeting included a resolution passed that members of the Eighth District would not participate in further governmental medical programs. Another interesting point of the meeting was that the Eighth District Association recognizing the paucity of information that it has had concerning various bits of legislation coming up in our national congress, has asked that at their own cost, excerpts and abstracts of pending health legislation bills be circulated to all members of the Eighth District. This reflects concern by all members in the Eighth Medical District concerning the recent inroads on medicine by the government.

Elections were also held at this meeting. The president-elect of the Eighth District Medical Society is Dr. Eugene Gillum of Portland. The secretary-treasurer is Dr. James Fitzpatrick of Portland.

The meeting was then adjourned and an enjoyable evening was had. There was a large banquet with Dr. Otis Bowen, Governor of the state of Indiana as the main speaker of the evening.

RICHARD INGRAM, M.D.
Trustee

Ninth Trustee District



WILLIAM SHOLTY, M.D.
Trustee

The 1974 Ninth District Medical meeting was held Thursday, June 13, 1974, at the Frankfort Country Club. The Clinton County Medical Society was host. Dr. Lee Dupler served as general chairman.

The business meeting was well attended (32). Dr. Vincent Santare, chairman of the ISMA Board of Trustees, discussed PSRO problems. Dr. James Harshman, AMA delegate and Eleventh District trustee, discussed the problems between the AMA Board and the House of Delegates. Dr. Peter Petrich, our Blue Shield representative, discussed Blue Shield problems, peer review and the Future Planning Committee. Dr. William Sholty announced that he had a copy of the slides prepared by Dr. Blaisdell. These are offered for anyone's use in the district. These bring out the bad points of PSRO.

Mr. Steve Tope, representative of the Blue Cross-Blue Shield, was introduced.

We had an innovation as far as the Ninth District was concerned. Each Ninth District commission representative gave a report on his commission. This was very well received. Dr. Max Hoffman was reelected our alternate trustee.

Next year's host will be the Jasper-Newton County Medical Society. The location and the date of the meeting has not been announced.

Mr. Phil Wise gave the program at the dinner meeting. He is a local humorist and the program was well received.

WILLIAM SHOLTY, M.D.
Trustee

Tenth Trustee District



VINCENT J. SANTARE, M.D.,
Trustee

The Tenth District, as represented by Lake County, began its year with the inauguration of Dr. Walfred (Chick) Nelson as president of Lake County Medical Society in January at the Merrillville Holiday Inn. At this meeting Governor Otis R. Bowen was the speaker and Senator Vance Hartke also attended the meeting and spoke to the society on pertinent local political problems. Dr. David Ross of Gary was installed as vice-president and Dr. Thomas Gehring of Merrillville as secretary of the Lake County Medical Society.

During the course of the year, the Calumet Foundation for Medical Care applied for a planning grant for PSRO activities and was approved for such a grant. The Foundation has been endorsed and consists of members of Lake and Porter county medical societies. Since the PSRO area also includes LaPorte County, a new organization will be set up named CALPRO, which will plan for peer review activities in the three county area. Directors of CALPRO organization will be selected from the Bed Utilization Review Committees of each of the hospitals in the three county medical societies, and an attempt will be made to restrict this particular function to the physicians of the area.

Dr. Alfred Kobak of Valparaiso has presided as the president of Porter County Medical Society. He will be succeeded by Dr. Leon Armalavage of Valparaiso. The Porter County Medical Society had an interesting county meeting on PSRO activities, and has been active in the establishment of Emergency Medical Services in this county.

The Tenth District meeting was postponed until September 25, 1974. The meeting will be held at the Valparaiso Country Club. The election of a Trustee to succeed Dr. Vincent J. Santare will be held at this meeting.

VINCENT J. SANTARE, M.D.,
Trustee

Eleventh Trustee District



JAMES A. HARSHMAN, M.D.
Trustee

Last year my report dealt with three areas of concern which were being discussed in the Eleventh District, namely, the physician shortage, PSROs and drug abuse. The same report could have been submitted again this year and a few more items could be added to the list, such as delineation of staff privilege, increasing governmental interference with the private practice of medicine, confidentiality of medical records and national health insurance, to name a few. The solutions to these and other problems will not be easy, and in many instances, not to our liking. Organized medicine still remains our most effective means by which we can address the problems. For this reason, it is imperative that all physicians participate in activities of their respective societies.

Our annual meeting was held last year at Marion where we observed the 125th Anniversary of the Grant County Medical Society. There was a large turnout for the event.

Election for district officers was held and Dr. Joe Bean was elected president, Dr. Fred Poehler was elected secretary-treasurer.

Cass County will host our next meeting which will be held on September 18, 1974, at Logansport.

JAMES A. HARSHMAN, M.D.
Trustee

Thirteenth Trustee District



G. BEACH GATTMAN, M.D.
Trustee

The Thirteenth District Medical Society held its annual meeting at Plymouth, September 12th. Preceding the meeting a golf outing was held at the Plymouth Country Club.

The business meeting was held at the American Legion Club of Plymouth and we had the best attendance of our district in a number of years. Dr. James Rimel, president of the district, conduct-

ed the meeting. Along with the usual business we also had reports from the commission members highlighting their activities for the year. The trustee's report was next, highlighting the Board of Trustees activities for the year. Dr. James H. Gosman, president of ISMA, gave a short talk.

Dr. Jack Hannah, Elkhart, was elected president for 1973-74; Dr. John Hildebrand, Jr., South Bend, was elected president-elect; Dr. David Spaulding, Mishawaka, was reelected secretary-treasurer. Dr. Donald Chamberlain, South Bend, was reelected alternate trustee.

Following the regular business meeting there was a panel discussion on PSRO with Dr. James Harshman, trustee of the Eleventh District and an AMA delegate, who gave a very thoughtful dissertation.

Following dinner a drawing was made for door prizes.

Our main speaker for the evening was Dr. Otis R. Bowen, Governor.

Our district had several extra meetings during the past year. The first was for delegates and officers of the county societies, which was poorly attended. The second was with the St. Joseph County Society and both of these had to do with PSRO.

The next meeting of the district will be at the Elcona Country Club in Elkhart on September 12, 1974.

G. BEACH GATTMAN, M.D.
Trustee

Editor of The Journal

The budget for *The Journal* for this fiscal year was established with the expectation of a deficit. However, the financial picture was accurately predicted and, while various items in the budget have varied, the totals are within the total budget and should also be in balance on September 30.

The Roster Issue is the most expensive one of the 12 but it is also probably the most useful. The Roster this year was the largest ever. It contains reference information which has been increased a little each year. Its printing bill was a little over $10,000, about five times the cost of the average issue.

National advertising revenue for the first half of the fiscal year is off by a few hundred dollars but state and local advertising was up by over $1000, making the total ad revenue for that period some $360 over the same period last year.

Special issues, other than The Roster, were one commemorating the recent additions to St. Francis Hospital of Beech Grove, the usual February Heart Month issue for cardiovascular disease, and the March issue which highlighted geriatrics.

A new addition is a series of Seminars from Riley Children's Hospital under the general sponsorship of Dr. Joseph F. Fitzgerald, associate professor of pediatrics. This series will continue indefinitely on an approximately bi-monthly basis.

This year *The Journal* has been well supplied with scientific articles. In fact, the limitation of size of issues due to the low advertising revenue has changed what would be a normal supply into an overabundance.

FRANK B. RAMSEY, M.D.
Editor

Delegates to AMA

Indiana's delegates to the American Medical Association's 123rd annual meeting, June 22 through 27, in Chicago, returned home defeated on two of their major undertakings.

The campaign to reelect Dr. Donald E. Wood, Indianapolis, to a second term on the Board of Trustees and the delegation's effort to stimulate a tide for repeal of PSRO both met with disaster.

A general uprising seemed to be the mood of the House of Delegates when only one former trustee was returned to his office. All the other vacancies, five in fact, were filled by new members of the board.

PSRO stance of the House of Delegates was a shocking one as far as the Indiana delegates were concerned. The ISMA had introduced a resolution before the House calling for direct repeal of the provisions of PSRO and Public Law 92-603. Reference Committee "A" had 25 resolutions dealing with PSRO before it for consideration.

Scheduled as a special order of business for 1:00 Wednesday afternoon, the House suspended the rules to take up Item 21 of Reference Committee A's Report, which dealt with the PSRO situation. The Chair called upon the chairman of the Reference Committee to review section 21 of their report, which he did, and then the political maneuvers began. A Dr. Hildebrand of Wisconsin was immediately recognized after the report was read. Dr. Hildebrand called for adoption of the Reference Committee Report and called for the previous question, which was to terminate debate. The question of closing debate carried by a standing vote of 202 to 24.

The adoption of the Reference Committee Report was then placed before the House and it carried by a vote of 185 to 57. This ended all debate on the PSRO question and the statement adopted by the House of Delegates is as follows:

RESOLVED, That this House of Delegates instruct the Board of Trustees of the Association to direct its efforts to achieve constructive amendments to the PSRO law and to ensure appropriate regulations and directives, with particular effort directed at amending those sections of the law which present potential dangers in the areas of confidentiality, malpractice, development of norms, quality of care, and the authority of the Secretary of HEW; and be it further

RESOLVED, That the Association should continue its efforts to achieve legislation which allows a profession to perform peer review in accordance with the profession's philosophy and the best interest of the patients; and be it further

RESOLVED, That individual state associations which elect non-participation shall not be precluded from such a position by this association's policy statement, but should be urged to develop effective non-PSRO review programs which embody the principles endorsed by the profession as constructive alternatives to PSRO; and be it further

RESOLVED, That if ongoing evaluation of the PSRO program reveals that it does, in fact, adversely affect the quality of patient care, or conflict with association policy, the Board of Trustees be instructed to use all legal and legislative means to rectify these shortcomings.

The Indiana Delegation made a strong stand for repeal of PSRO in the Reference Committee and on the floor of the House prior to the reading of the Reference Committee report.

Eugene F. Senseny, M.D., Fort Wayne, was floor leader of the delegation who attended the meeting in full force. Working throughout the long meeting with early morning breakfast meetings and continuing caucuses were Delegates James A. Harshman, M.D., Kokomo; Malcolm O. Scamahorn, M.D., Pittsboro; Patrick J. V. Corcoran, M.D., Evansville; and Lowell H. Steen, M.D., Hammond.

Alternates attending were A. Alan Fischer, M.D., Indianapolis; Ross L. Egger, M.D., Daleville; Kenneth O. Neumann, M.D., Lafayette; Thomas C. Tyrrell, M.D., Hammond; and Peter R. Petrich, M.D., Attica.

Also in attendance were President Joe Dukes, M.D., Dugger; President-elect Gilbert M. Wilhelmus, M.D., Evansville; and Board Chairman Vincent J. Santare, M.D., Munster.

Also working with the delegation were Frederic Schoen, M.D., Fort Wayne, alternate delegate from the AMA Section on Family and General Practice; Joseph E. Walther, M.D., Indianapolis, delegate, AMA Section on Gastroenterology; Sprague H. Gardiner, M.D., Indianapolis, delegate AMA Section on Obstetrics and Gynecology; Myron H. Nourse, M.D., Indianapolis, delegate, AMA Section on Urology; and Guy A. Owsley, M.D., Hartford City, member of the AMA Council on Medical Service.

Among other guests who attended a breakfast meeting with the delegation

were David G. Crane, M.D., Bloomington, chairman of the ISMA's Commission on Public Information, and his father, George Crane, M.D., noted health columnist.

In addition to the controversial PSRO issue, the AMA House of Delegates established a change in the method of electing AMA trustees, approved the need for additional safeguards to preserve the confidentiality of medical records, and new recommendations which affect the relationship between hospitals and hospital medical staffs.

Meeting for a total of 19 hours and 38 minutes, the House acted on 66 reports and 137 resolutions for a total of 203 items of business.

The House approved bylaws changes which replace the "slot method" of electing trustees by the "simultaneous election of candidates to several positions of equal rank," in which all candidates run for board vacancies on a single ballot. Under the new method, trustees for full, three-year terms are elected first, followed by the selection of trustees to fill unexpired terms. Election of the AMA president-elect, vice-president, and speaker and vice-speaker of the House remains on a separate basis.

Delegates selected Max Parrott of Portland, Oregon, as president-elect. In addition to Dr. Parrott, others elected or reelected to positions in the Association were: vice-president—Joseph M. Ribar, Alaska; speaker of the House—Tom E. Nesbitt, Tennessee (reelected); vice-speaker of the House—William Y. Rial, Pennsylvania (reelected); trustees, for three-year terms—Daniel Cloud, Arizona; James M. Blake, New York; Hoyt D. Gardner, Kentucky; Raymond T. Holden, District of Columbia (reelected). For the unexpired two-year term of James H. Sammons, AMA executive vice-president-designate, Frank J. Jirka, Illinois, and for the unexpired one-year term of Dr. Parrott, Joe T. Nelson, Texas.

Addressing the House on Tuesday, June 25, Vice President Gerald Ford advocated some form of national health insurance but warned that in the process of its development there should be no further erosion of patient confidentiality. Though it had been rumored that Ford would address the PSRO issue, his only passing reference was:

"I've been getting a lot of free advice lately on how to run my business. I have not necessarily followed this advice. So, I won't give you any free advice on how to run your business. In my view on PSRO, (P)oliticians (S)hould (R)emain (O)ut of it."

Ford said a national health insurance program is necessary because of the prohibitive cost of catastrophic illnesses and the need to more effectively use and distribute medical resources. While declaring the physician should work for his patients and "not for the bureaucrats in Washington," he added that the "government must do for the individual citizen what he cannot do for himself."

In his inaugural address on Wednesday, June 26, Dr. Malcolm C. Todd, the new AMA president, urged the AMA to sponsor the development of a "national policy on health" to place needs and goals in focus. He said "a tremendous amount of confusion" exists on the health-care scene and is reflected in plans being advanced in Washington and elsewhere.

"It is high time to put the health-care state of the Union into its true perspective, before lack of perspective leads to waste of effort, waste of money, waste of hope," he said.

Dr. Todd asked the delegates to consider sponsoring a National Academy of Health to formulate his proposed national policy. The academy, he said, would give both private and public sectors of health care "an open forum and framework in which to exchange views, pinpoint health-care needs, evaluate total health care resources, and arrive at some common sense of purpose, with sound programs, goals and priorities."

Dr. Todd noted a national policy on health also is called for in Congressional bills that would make health services a public utility. Under one such proposal, a five-man federal commission would make policy recommendations. Such a policy would be "destructive," he said, unless the private sector of care seizes the initiative in formulating it.

Two statements on national health insurance were adopted after lengthy debate. One calls on the Board of Trustees to cooperate with state associations "to attempt to devise mechanisms mutually acceptable to the private medical and insurance communities which will ensure the provision of health insurance coverage through the purchase of private health insurance, and to seek means to secure favorable Congressional and public support for their adoption."

During discussion, it was pointed out that the addition to the NHI policy does not affect AMA support for Medicredit, but is intended to stimulate new health insurance mechanisms. The second resolution calls on the AMA and component associations to work to detach "any national health insurance program from the controlling intrusions of existing PSRO laws and regulations."

The House adopted two resolutions bearing on drugs. One directs the AMA to continue its support of the pharmaceutical industry in efforts to develop and market pharmaceutical products meeting proper standards of safety and efficacy. The other resolution directs the AMA to "exert all efforts to amend or repeal the Kefauver-Harris" drug amendments of 1962, which gave the FDA broad new powers in drug manufacturing and marketing, and which critics of the FDA contend has tended to stifle the developing and marketing of new drugs in the United States.

The House went on record as being opposed to certain bills in Congress which would replace the federal "Health Professions Educational Assistance Act" which expired June 30. Under the bills, comprehensive health planning programs would be replaced with public utility-type bodies which would control certain aspects of health education and health-care delivery, and medical licensure. An amended resolution adopted by the House directs the Board of Trustees to mobilize AMA membership in opposition to offensive sections of the proposed legislation and take strong actions on other fronts.

In other actions affecting physicians and the government, and other third parties, the House:

—Directed the AMA to seek an extension of from 30 to 90 days to respond to proposed health regulations printed in the Federal Register, and to see that government agencies using the Federal Register for rule-promulgating purposes be urged to hold public hearings on the merits of proposed legislation.

—Called on the AMA to oppose the concept of claims rejection on the basis of "diagnostic admission" or "lack of medical necessity" without prior physician notification, and to recommend a peer review mechanism be established independent of the third-party carrier to review claim conflicts with such mechanisms to be established by existing medical foundations, medical societies or other independent peer review organizations.

—Requested the AMA to work with third parties to secure increased acceptance of the AMA uniform health insurance claim form and urged state associations to encourage acceptance of the form by insurance commissioners, and, if necessary, through state legislation.

—Urged continued AMA efforts to prevent future imposition of government fee controls, and opposed the mandatory imposition of a "Healthcard" as the payment mechanism under the administration's national health insurance plan, and instead, reaffirmed the right of the physician to bill patients directly.

—Adopted two reports bearing on confidentiality of medical records. Report I of the Council on Medical Service described a wide-ranging series of proposals to enable the medical profession and insurance companies to "maintain the confidentiality and security of patient information." Report S of the Board of Trustees noted that the Council on Legislation is developing model legislation as a guide to possible state legislation to preserve confidentiality and that a model bill should be ready for consideration by the House at the 1974 Clinical Session in Portland, Oregon.

In another action affecting physicians

and the public, the House directed that the AMA continue to inform the public and the profession of the potential problems and risks in permitting the nonphysician substitution of drugs of choice prescribed by physicians and that state associations support this position before state legislatures considering laws which would allow drug substitutions.

The House adopted the 104-page "Report on Physician-Hospital Relations, 1974," compiled by the Council on Medical Service and its Committee on Private Practice. An update of an earlier report made in 1964, the 1974 version contains 14 specific recommendations to cope with problems developing between some hospitals and their medical staffs. Among other things, the recommendations are aimed at protecting medical staffs against unilateral action by hospital governing boards relative to staff bylaws, rules and regulations.

A resolution calling on the AMA and constituent societies to "institute a nationwide public education program to inform the public" of malpractice problems, and for the AMA to "spearhead state and federal legislation" to correct malpractice inequities, was referred to the Board of Trustees and its Committee on Insurance for report back at the 1974 Clinical Session.

JAMES A. HARSHMAN, M.D.
EUGENE F. SENSENY, M.D.
MALCOLM O. SCAMAHORN, M.D.
PATRICK J. V. CORCORAN, M.D.
LOWELL H. STEEN, M.D.
Delegates

A. ALAN FISCHER, M.D.
ROSS L. EGGER, M.D.
KENNETH O. NEUMANN, M.D.
THOMAS C. TYRRELL, M.D.
PETER R. PETRICH, M.D.
Alternate Delegates

Resolutions

(See also pages 855 and 881)

Resolution No. 74-9

Introduced by: Clark County Medical Society

Subject: DISCONTINUANCE OF MEMBERSHIP IN THE AMA

Whereas, the AMA leadership and House of Delegates, as shown by their actions at the Chicago meeting in June 1974, do not intend to work for repeal of PSRO legislation; and

Whereas, their course of action has been one of collaboration with a Federal Agency (HEW) whereby they are rendering their membership totally subservient to the director of that agency (Secy. of HEW); and

Whereas, they have urged their membership to similarly collaborate; and

Whereas this same leadership of the AMA has entered into a contract with HEW to develop standards of diagnosis and treatment to be imposed on its membership; and

Whereas the Clark County Medical Society feels that these actions do not represent the best interests of medicine or of improved patient care; therefore, be it

Resolved, That, until such time as the leadership of AMA shows positive evidence of supporting the wishes and best interests of its membership and of medicine as a whole, the Clark County Medical Society is urging its members to discontinue membership in the AMA and to consider joining an organization which does more adequately represent us; be it further

Resolved, That the ISMA House of Delegates direct the ISMA leadership to investigate and report to its members its findings regarding which organizations other than the AMA, but particularly Congress of Medical Staffs and Association of American Physicians and Surgeons, will more adequately represent medicine as a whole and the individual physicians as a free agent.

Resolution No. 74-10

Introduced by: Board of Trustees

Subject: USE AND ACCEPTANCE OF THE STANDARD AMERICAN MEDICAL ASSOCIATION'S CLAIM FORM BY INSURANCE CARRIERS DOING BUSINESS IN INDIANA

Whereas, Physicians are constantly required to fill out insurance report and claim forms from many insurance commercial insurers; and

Whereas, The insurance carriers have not standardized their report claim forms, thereby serving to confuse the physician and unduly complicate his work; and

Whereas, The American Medical Association has standardized a form which should be satisfactory to the physician and the commercial insurer; therefore, be it

Resolved, That the Indiana State Medical Association take whatever action is necessary to make it compulsory that insurance carriers doing business in Indiana use and accept the standard claim form for physician and patient claims and reports in this State.

Resolution No. 74-11

Introduced by: Committee on Future Planning

Subject: ANNUAL MEETING

Referred to:

Whereas, Several state medical associations hold their annual meetings concurrently with the meetings of state specialty societies; and

Whereas, The Indiana Society of Internal Medicine and the Indiana Chapter of the American College of Physicians have held their annual meetings jointly during the annual ISMA convention with resultant benefits in attendance and quality of programs; and

Whereas, economies of time and effort could result for more of the physicians of Indiana by combining the meetings of the statewide professional medical societies; and

Whereas, facilities for achieving this are now available; be it

Resolved, that ISMA schedule its Annual Meeting so that the scientific sessions not conflict with business meetings of the association; and be it further

Resolved, That negotiations be initiated with the Indiana Academy of Family Physicians, the various other state specialty societies and the Indiana University School of Medicine to develop a coordinated scientific and educational annual program of meetings during one period of time, which would be preceded and/or followed by the business activities of the various organizations, with enhancement of effectiveness and benefits, together with promoting understanding and cooperation among all segments of Hoosier medicine.

Reports of Committees

EXECUTIVE COMMITTEE

The Executive Committee met at the conclusion of the Board of Trustees meeting following the Annual Convention, and welcomed Drs. Vincent Santare and William Clark as new members. By secret ballot, Dr. Donald M. Kerr was elected chairman of the Executive Committee for the coming year.

The officers then signed the various bank cards and necessary papers. There being no other business, the meeting adjourned.

The Executive Committee met on five occasions since the last Convention, having met on November 10, 1973, January 19, March 12, April 20 and June 15, 1974.

Inasmuch as the minutes of the meetings of the Executive Committee have been published in THE JOURNAL, and copies are available for each member of the reference committee, I will save your time by not going into detail in reviewing each of these meetings.

The Committee in its meetings has been involved heavily in a large number of items which came before it, many of which were referred to the Board of Trustees for their review, and action in each matter adopted by the Executive Committee was sent to the Board of Trustees for their concurrence.

On March 13, 1974, the Executive Committee made its annual trek to Washington and hosted a dinner for the Indiana delegation in Congress. We spent a day visiting the congressmen and their offices, and concluding our day's activities with a reception and dinner. It was interesting that this year, for the first time, both senators and all 13 of the congressmen showed up for the dinner activity. It is the belief of all of us who met with them that we made quite a few brownie points with our Indiana delegation, and we are sure that we developed a much closer liaison with them, which will be necessary in coming months as legislation is presented before Congress. At least we believe we have a method now of communicating with them and expressing our views on much of this legislation.

The Committee met on January 19 for the purpose of regular activities, plus preparation of the budget for the fiscal year ending September 30, 1974. After review of the budget and discussion, the matter of the budget was referred to the Board of Trustees for their approval.

Medical Defense Activities

1. Malpractice Cases. A year ago at the time of this report, August 1973, the following six cases were pending before the committee:
   Case 307 — Suit filed March 22, 1962. Closed. (Expense $1,497.73)
   Case 313 — Suit filed September 5, 1967. Pending. (Expense to date $600.00)
   Case 314 — Suit filed approximately July 6, 1970. Pending.
   Case 316 — Suit filed July 2, 1970. Pending.
   Case 317 — Date suit was filed unknown. Closed. (Expense $644.00)
   Case 318 — Date suit was filed unknown. Pending.
   Since August 1, 1973, and to August 1, 1974, three new cases have been filed.

2. Medical Defense Fund Statement from July 1, 1973, to June 30, 1974;

Bank balance, July 1, 1973	$19,891.06
Receipts	6,328.85
Total cash and receipts, June 30, 1974	26,219.91
Disbursements	1,462.95
Balance on hand, June 30, 1974	$24,756.96
U. S. Treasury Bonds	25,526.53
Due from General Fund	720.15

The Journal

Listed below is a comparative report of *The Journal* operations over the past several years and the first six months of 1974, as follows:

The first table shows the number of journal pages for the past six years (includes inserts).

Year	Reading	% Reading	Adv. Pages	% Adv. Pages	Total Pages	Av. No. Pages Per Issue
1968	1068	61	696	39	1764	147
1969	1041	67	509	33	1550	129
1970	1131	74	403	26	1534	128
1971	970	70	426	30	1396	116
1972	933	69	433	31	1366	113
1973	877	73	321	27	1198	100

The table below shows the total printing costs of *The Journal:*

Year	Total Printing Costs	No. of Pages
1969	$42,916.62	1312
1970	44,520.84	1346
1971	40,542.21	1232
1972	41,789.70	1106
1973	42,642.43	1028
1974 (6 mos.)	24,786.99	560

A comparison of advertising revenues for the first six months of the last four years, with a like figure for 1974, is as follows:

Year (Jan.-June)	Sold by State Medical Journal Adv. Bureau	Sold direct By Journal	Total
1970	$15,791.12	$2,268.80	$18,059.92
1971	13,128.30	1,821.89	14,950.19
1972	17,869.96	1,622.60	19,492.56
1973	10,938.94	2,134.95	13,073.89
1974	10,280.92	3,151.00	13,431.92

Membership Report

Total Members

	December 1972	December 1973
ISMA	4,587	4,698
AMA	4,246	4,348
	July 31, 1973	July 31, 1974
ISMA	4,625	4,743
AMA	4,292	4,416

DISTRICT REPORT AS OF JULY 31, 1974
+ Gain — Loss

District	ISMA	AMA
1	+ 12	+ 13
2	+ 9	+ 2
3	+ 6	— 2
4	+ 1	+ 4
5	— 5	— 4
6	+ 2	+ 6
7	+ 43	+ 45
8	— 3	+ 11
9	+ 2	+ 2
10	+ 34	+ 27
11		+ 4
12	+ 16	+ 15
13	+ 1	+ 1
	+118	+124

DEATHS

December 1973	59
As of July 31, 1974	28

COUNTY/DISTRICT MEMBERSHIP REPORT

	Dec. 31, 1973 ISMA	July 31, 1973 ISMA	July 31, 1974 ISMA	July 31, 1974 AMA
1st DISTRICT				
Gibson	11	11	13	13
Perry	7	7	7	7
Pike	2	2	2	2
Posey	6	6	6	6
Spencer	5	5	4	4
Vanderburgh	274	268	279	261
Warrick	6	6	6	5
TOTAL	311	305	317	298

2nd DISTRICT				
Daviess-Martin	19	18	20	15
Greene	16	16	16	12
Knox	45	45	44	42
Owen-Monroe	97	96	102	83
Sullivan	14	13	15	14
TOTAL	191	188	197	166
3rd DISTRICT				
Clark	54	53	55	43
Dubois	23	23	24	21
Floyd	47	46	44	41
Harrison-Crawford	9	9	9	9
Lawrence	40	37	41	35
Orange	6	6	6	6
Scott	8	8	8	8
Washington	8	7	8	7
TOTAL	195	189	195	170
4th DISTRICT				
Bartholomew-Brown	64	64	69	57
Dearborn-Ohio	14	15	15	14
Decatur	10	10	8	8
Jackson-Jennings	21	21	20	20
Jefferson-Switzerland	28	28	27	24
Ripley	11	11	11	10
TOTAL	148	149	150	133
5th DISTRICT				
Clay	15	15	14	14
Parke-Vermillion	14	14	14	13
Putnam	20	20	18	18
Vigo	125	121	119	115
TOTAL	174	170	165	160
6th DISTRICT				
Fayette-Franklin	18	18	18	17
Hancock	26	25	26	25
Henry	39	38	38	34
Rush	12	12	12	12
Shelby	22	20	22	20
Wayne-Union	76	75	74	70
TOTAL	193	188	190	178
7th DISTRICT				
Hendricks	23	23	26	21
Johnson	36	36	35	32
Marion	1121	1090	1129	1125
Morgan	22	21	23	21
TOTAL	1202	1170	1213	1199
8th DISTRICT				
Delaware-Blackford	127	127	131	103
Jay	17	17	14	13
Madison	106	103	97	75
Randolph	16	16	18	13
TOTAL	266	263	260	204
9th DISTRICT				
Benton	9	9	7	6
Boone	16	16	18	15
Clinton	15	15	13	11
Fountain-Warren	12	12	11	10
Hamilton	17	17	18	13
Jasper	9	9	9	9
Montgomery	24	24	25	25
Newton	5	5	4	4
Tippecanoe	158	154	157	144
Tipton	10	10	12	12
White	9	9	8	8
TOTAL	284	280	282	257
10th DISTRICT				
Lake	448	440	475	435
Porter	78	78	77	75
TOTAL	526	518	552	510
11th DISTRICT				
Carroll	8	8	8	8
Cass	32	32	31	27
Grant	79	79	82	81
Howard	72	72	71	67
Huntington	18	16	18	17
Miami	13	13	13	13
Wabash	30	30	27	21
TOTAL	250	250	250	234
12th DISTRICT				
Adams	12	12	13	13
Allen	318	317	327	299
DeKalb	19	19	19	15
LaGrange	11	11	9	9
Noble	14	14	16	16
Steuben	12	13	13	13
Wells	44	44	51	50
Whitley	15	15	13	13
TOTAL	445	445	461	428
13th DISTRICT				
Elkhart	115	114	118	107
Fulton	8	8	7	7
Kosciusko	13	13	18	14
LaPorte	101	101	94	82
Marshall	19	19	19	18
Pulaski	4	4	4	2
St. Joseph	245	243	243	242
Starke	8	8	8	7
TOTAL	513	510	511	479

SUMMARY

1st District	301	305	317	298
2nd District	191	188	197	166
3rd District	195	189	195	170
4th District	148	149	150	133
5th District	174	170	165	160
6th District	193	188	190	178
7th District	1202	1170	1213	1199
8th District	266	263	260	204
9th District	284	280	282	257
10th District	526	518	552	510
11th District	250	250	250	234
12th District	445	445	461	428
13th District	513	510	511	479
	4,698	4,625	4,743	4,416

DONALD M. KERR, M.D.,
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JOSEPH E. DUKES, M.D.
GILBERT M. WILHELMUS, M.D.
VINCENT J. SANTARE, M.D.
HUGH K. THATCHER, JR., M.D.
WILLIAM R. CLARK, M.D.

Grievance Committee

The Grievance Committee has not met during the past year as most of the complaints received have been handled by the local county medical society. Three new complaints were received, one has been resolved, the other two are pending. Of the six cases pending as of August 1973, one has resulted in a law suit, one has been resolved, and the other four are pending with no further word being received. In view of the nature of the complaints and the information received, calling a meeting of the committee was not deemed necessary.

The county medical societies are to be commended for handling more and more complaints at the local level.

The Grievance Committee wishes to thank the members of ISMA who have been called upon to assist in discharging its responsibility.

RICHARD S. BLOOMER, M.D.,
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KENNETH WILHELMUS, M.D.
HARRY L. CRAIG, M.D.
THOMAS C. TYRRELL, M.D.
LAWRENCE K. MUSSELMAN, M.D.
GENE MOORE, M.D.

Future Planning

The Future Planning Committee has held two meetings, April 20 and June 15, both at the Association headquarters.

Resolution 73-11, referred to the committee by the House of Delegates, urged that the House of Delegates have a meeting in April or in May; and if a second meeting be needed, that it be held in October—November, and that only one of these be accompanied by a scientific session. After extensive discussion, the committee recommends that Resolution 73-11 not be implemented. It was further decided, on the basis of past experience with special meetings of the House of Delegates, that the present format of one annual meeting in October be continued, but that a poll of the next meeting of the House of Delegates be made to determine the advisability of holding an optional one-day spring meeting to deal with urgent matters including impending legislative issues.

In view of the steadily decreasing participation and support of exhibitors in the annual convention, with consequent loss of revenue, the committee urges that specialty societies be contacted with a proposal that their meetings be jointly scheduled with those of the ISMA. The favorable experience of joint sessions of the Section on Internal Medicine with the regional meetings of the College of Physicians and the Indiana Society of Internal Medicine serves as a favorable harbinger of the potential benefits, somewhat comparable with the annual meeting of the Kentucky Medical Association

with its component specialty societies. In particular, the Indiana Academy of Family Physicians has led the way in demonstrating what can be accomplished in this area. The committee strongly endorsed initiating negotiations with the Indiana Academy of Family Physicians in jointly developing this concept.

A communication from Dr. C. Dyke Egnatz of Schererville about the convention format was considered. It embodied suggestions essentially consonant with the foregoing recommendations. It was directed that a letter of thanks to Dr. Egnatz express appreciation of his contribution.

The committee recommended that the subject of fees for professional services, for surgical assistants, for salaries to interns and residents, for charges for laboratory screening procedures not ordered by physicians, for emergency department services and various other third-party economic intervention into medical practice be referred to the Commission on Medical Economics and Insurance for further study and recommendation.

The committee/commission structure of the Association was also considered. It was concluded that standing committees, such as the Executive Committee, Future Planning, and Sports and Medicine Committee, should not be disturbed nor should the standing and the ad hoc committees of the Board of Trustees be altered. Likewise, appropriate ad hoc committees for special needs should continue to be appointed by the president and disbanded when they have accomplished their task.

It is suggested that a new commission structure be established with appropriate committees to carry out missions assigned to them. Each committee should be carefully evaluated as to its mission and there should be careful definition of goals and objectives for each commission. Each commission would be composed of seven members and whether these should be selected geographically could be a matter for determination at a later date. Committees of the commissions should be not more than five members and may be drawn from members of the Association who are not appointed to the commission itself; the chairman of each such committee in all likelihood should be a member of the commission.

The recommended new commissions are as follows: (1) Commission on Medical Education (which would combine the accreditation program, the education program and licensure), (2) Commission on Medical Service (combining the duties of the present commissions on Governmental Medical Services, Public Health, Voluntary Health Agencies, and Medical Economics and Insurance), (3) Commission on Legislation, (4) Commission on Constitution and Bylaws, (5) Commission on Public Relations (to embody the speakers' bureau, public information, and special activities) and (6) a Commission on Convention Arrangements.

To accomplish the foregoing, the following commissions would be replaced or incorporated into one of those proposed above. (1) Aging, (2) Emergency Medical Services, (3) Governmental Medical Services, (4) Interprofessional Relations, (5) Medical Economics and Insurance, (6) Public Health, (7) Public Information, (8) Special Activities, (9) Voluntary Health Agencies.

Therefore, the structure would be: Executive Committee, the Future Planning Committee, the Committee on Sports and Medicine, and the six commissions enumerated above, each consisting of seven members with approximately 10 committees of an additional four members each. The total involvement in the commission and committee structure would approximate 82 members, as contrasted with the 254 members now involved.

As to the membership of the Future Planning Committee itself, it is recommended that there be fewer ex officio members; there should be one representative who has been a president of the Association within the previous five years; one should be a student physician; another a house officer; and the additional members be selected either by the president or the Board of Trustees—not to exceed a total of 12 members.

In considering the purposes, scope of action, and goals of the committee, it is pointed out that housekeeping matters of the Association are not the proper purview of this committee. The president and the speaker should be so advised. The committee should give consideration to the needs of the Association and should hold discussions, if needed, with management consultants and should seek sources of information such as the State Board of Health, Blue Shield, and the Regenstrief Foundation in the gathering of data. Concepts should be developed as to the directions in which the Association is headed, particularly with mid-term and long-term effects. Greater participation of all physicians in the affairs of the Association should be sought as a specific objective of the Future Planning Committee.

PATRICK J. V. CORCORAN, M.D.
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PETER R. PETRICH, M.D.
DeWAYNE HULL, M.D.
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JAMES H. GOSMAN, M.D.
JOHN M. PARIS, M.D.
JOHN O. BUTLER, M.D.
JOHN M. PARIS, JR.
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VINCENT J. SANTARE, M.D.
DONALD KERR, M.D.
FRANK B. RAMSEY, M.D.
JOHN W. BEELER, M.D.
WILLIAM R. CAST, M.D.

Student Loan Committee

No student loan applications have been received in the last four years.

To date, 108 loans, totalling $95,500, have been granted. During the last year four notes were paid in full. There are nine open notes at this time, totalling $10,883.35. No notes are in interim.

The loan fund of ISMA from 1955 to 1963 had loaned money to 118 students, in all, a total of $58,458.36. This total amount has been repaid. The Guaranteed Loan Plan with Indiana National Bank was started in December 1963, and has on deposit $20,810 of ISMA money. This guarantees loans up to $260,000.

After much discussion, evaluation of the Indiana National Bank/ISMA contract is being currently studied and further changes in loan guidelines are being considered.

A supplemental report will be made at the annual 1974 House of Delegates meeting.

MALCOLM O. SCAMAHORN, M.D.
Chairman
JOE DUKES, M.D.
PAUL W. HOLTZMAN, M.D.
JAMES O. RITCHEY, M.D.
HUGH K. THATCHER, JR., M.D.
STEVEN C. BEERING, M.D.

Medical-Legal Review Committee

Article III, Section 3, of the Interprofessional Code adopted by the Indiana State Medical Association and the Indiana State Bar Association states in part:

> These appointees (three attorneys and three physicians), *if required,* will sit quarterly as a joint committee to review those court or administrative agency cases in which medical testimony appeared to the court, or administrative agency, attorney or attorneys or to the physician or physicians to have been so contradictory or improper as to indicate conscious deviation from the truth. In a like manner, they will review those cases called to their attention involving an attorney in which there is question of his exceeding propriety in his handling of medical witness, or in his efforts to introduce improper medical testimony.

There were no court or administrative actions during the past year which met the requirements of Article III, Section 3, cited above. However, the Medical-Legal Review Committee did meet on June 12,

1974, regarding several matters of interest to both medicine and law.

One of the major areas of concern is subpoenas. Numerous complaints had been received regarding the untimeliness or lack of necessity on the part of attorneys in subpoenaing doctors; and, on the other hand, the lack of cooperation on the part of physicians who have been subpoenaed. The committee indicated its desire to communicate to members of both professions those guidelines as set out in Article II, Section 5 of the Interprofessional Code regarding Subpoenas:

> It is expected that the attorney will in every instance make a good faith effort to arrange his client's expert medical evidence in ample time before the hearing to allow the physician time for special study, review, or other preparation. Such arrangements should include offer of compensation commensurate with the reasonable value of the professional services involved in preparing or offering testimony, or the time taken away from the physician's practice.
>
> In the event that medical evidence necessary to his client's cause cannot be obtained by prior arrangement, either because the physician has held himself unavailable or has been otherwise uncooperative, then the attorney may subpoena the medical expert, and he is obligated to answer the subpoena as is any other citizen.

The committee also dealt with a request for review of a particular physician's situation involving numerous malpractice lawsuits. The basis for the request for review was suspected harassment of the physician by the attorney. After briefly looking into the matter, the committee recommended that since they have no jurisdiction until after a hearing or trial has been concluded, the matter be investigated by the staff of the local hospital.

The issue of whether to eliminate, maintain, or increase the contribution to the Medical Defense Fund was also discussed by the committee. It was the general feeling of the committee that the fund should be continued at its present level, but that the monies should also be used in the future to help secure passage of malpractice arbitration legislation.

The next major area considered by the committee was the increasing incidence of medical malpractice lawsuits and the corollary problem of increased costs and decreased access to medical liability insurance. The committee reviewed and discussed several plans for screening panels, arbitration panels, and similar approaches designed to eliminate the "nuisance" lawsuits. The committee and its staff are undertaking an in-depth study of all actual and proposed plans, both statutory and non-statutory, with the ultimate objective of preparing a proposal for Indiana. This proposal would then be undertaken on a pilot study in one of the counties in Indiana to determine its feasibility and utility for statewide application. Further information on this subject will be available at the October House of Delegates meeting.

As chairman of the Medical-Legal Review Committee, I feel obligated to impress upon each of you the importance of the medical malpractice problem. Indiana is in the crisis stage *now* regarding every aspect of medical liability. High-risk, class 5 physicians (Ob-Gyn, Anesthesiology, Plastic Surgery, Neurosurgery, Orthopedic Surgery, etc.) are being hit the hardest at the moment, but the effects are being felt by all of us. This committee is working feverishly to stave off this growing menace.

JOHN W. BEELER, M.D.
Chairman
ROBERT R. KOPECKY, M.D.
JOSEPH G. S. WEBER, M.D.
JOHN O'CONNOR
WILLIAM HALL
GEOFFREY SEGAR
JAMES J. STEWART

Convention Arrangements Committees—1974

COMMISSION ON CONVENTION ARRANGEMENTS: Glen McClure, Sullivan, chairman; Edward M. Johnson, Terre Haute, vice-chairman; Claude Meyer, Jeffersonville; Harold W. Richmond, Columbus; James T. Anderson, Greenfield; Kenneth G. Kohlstaedt, Indianapolis; B. D. Wagoner, Union City; Howard R. Marvel, Lafayette; Adolph P. Walker, Munster; Bernard R. Hall, Logansport; Walter D. Griest, Fort Wayne; C. Herbert Ufkes, North Judson; Alvin J. Haley, Fort Wayne; S. O. Waife, Indianapolis; John L. Ferry, Hammond, and Mrs. James L. Stribling, Columbus.

GOLF TOURNAMENT: Malcolm L. Wrege, Indianapolis, chairman.

TENNIS TOURNAMENT: Dean A. Grove, Indianapolis, chairman.

AUXILIARY and WOMEN'S ACTIVITIES: Mrs. James L. Stribling, Columbus, general chairman; Mrs. B. L. Weisenberger and Mrs. Floyd W. Mohler, Columbus, co-chairmen.

ART and HOBBY SHOW: Mrs. Harry Siderys, Indianapolis, chairman.

SPECIAL COMMITTEE FOR 125TH ANNIVERSARY: Governor Otis R. Bowen, Indianapolis, chairman; Kenneth G. Kohlstaedt, Indianapolis; Glenn W. Irwin, Jr., Indianapolis; Mrs. Otis R. Bowen, Indianapolis; Irvin H. Scott, Sullivan, and Howard S. Wilcox, Indianapolis.

SCIENTIFIC EXHIBITS: W. P. Loh, Gary, chairman.

WOMEN PHYSICIANS: Glen McClure, Sullivan, chairman.

Reports of Commissions

Aging

Although the Commission on Aging has met only twice since the last annual report was filed, its members and staff have been quite active throughout the year working on medical problems of the aged and aging.

On August 8, 1973, representatives from the ISMA Commission on Aging met along with 60 other persons representing 39 organizations and agencies in the state of Indiana for the first Legislative Consortium sponsored by the Indiana Commission on the Aging and Aged. This Consortium was directed by the chairman of the legislative committee of the Indiana Commission on the Aging and Aged, Dr. W. Dean Mason.

At that first meeting, in addition to participating in workshops and discussions, the representatives from the ISMA Commission on Aging presented the "Position Statement of Medicare and Medicaid of the Commission on Aging of the Indiana State Medical Association." This position statement was readily accepted by the Consortium and was included briefly in the overall report submitted by the Consortium to the Governor. As you will recall, the position statement was prepared and presented to the House of Delegates at the 1973 annual meeting of the ISMA.

The ISMA representatives to the Consortium were also instrumental in presenting the "Death with Dignity Concept" and the idea of establishing a Gerontology Chair at the Indiana University School of Medicine.

The following legislative recommendations were accepted by the Indiana Commission on the Aging and Aged as a result of the Consortium and were presented to Governor Otis R. Bowen for possible action during the 1974 session of the Indiana General Assembly:

(1) An amendment to the Indiana School Bus Law in order to help older citizens of Indiana take advantage of public school transportation resources.

(2) A statutory amendment to permit the Annual Governor's Conference on Aging to be held on any campus of any state college or university.

(3) The adoption of better means of communication to inform older citizens regarding the features of the Indiana Probate Code.

(4) The passage of enabling legislation to allow city and county governments to appropriate funds for use by private organizations and institutions for projects designed to provide services to the elderly.

(5) That legislation be enacted to exempt the "home-delivered meals program" from Indiana State Sales Tax.

As a result of the first Legislative Consortium, the following beneficial legislative measures did pass the 1974 General Assembly: H.B. 1107, which allows school buses to be used to transport elderly people; S.B. 230, which permits governmental agencies to contract with not-for-profit organizations; and H.B. 1367, which exempts sales tax on home-delivered meals for persons who are confined to their homes.

Following the successes of the first Consortium a second Consortium was held on May 13, 1974, for the purpose of preparing legislation for the 1975 session of the Indiana General Assembly. Your commission was also represented at this meeting.

On April 21, 1974, the Commission on Aging met with Dr. J. O. Price, medical director of the Department of Public Welfare and with Mr. Al Kelly, executive secretary of the Indiana Nursing Home Association (formerly the Indiana State Welfare Director) to discuss problems of a medical nature regarding the aging population in Indiana.

At that meeting it was decided that the emphasis of the Commission on Aging should be limited to health matters of the aging population rather than being concerned with the fields of economics and social welfare. In discussing the health care problems of the aged and aging, Dr. Price pointed out that the most common complaints received by his department are

(1) Inadequate reimbursement under Title 18 and Title 19 for physician services. This is primarily due to the 75 percentile system of establishing physician's profiles. Dr. Price did point out that the profiles are reviewed and updated every July.

(2) Fear of PSRO restrictions, especially the imposition of punitive measures for failure to comply.

Mr. Kelly indicated that the major problem area in nursing homes is a failure of physicians to recertify their patients. Every patient in a skilled nursing home must be seen and recertified every 30 days. Every patient in an intermediate care facility must be seen and certified every 60 days.

The commission also voted to continue its efforts to provide for the establishment of a Gerontology Chair at the Indiana University School of Medicine. As indicated earlier in the report, this request was transmitted to the Indiana Commission on Aging and Aged.

The commission also discussed the "Quality of Life" meeting held recently in Chicago by the American Medical Association Commission on Aging. It was suggested that perhaps some of the panel members from that meeting could be invited to Indiana for a similar meeting sponsored by the ISMA Commission on Aging. At the time of this writing, this proposal is still in the planning stages.

ALBERT M. DONATO, M.D., *Chairman*
JOHN D. WILSON, M.D.
ROBERT O. BETHEA, M.D.
JOSEPH C. DUSARD, M.D.
PAUL E. HUMPHREY, M.D.
CLOYD L. DYE, M.D.
D. L. BUCKLES, M.D.
W. MARTIN DICKERSON, M.D.
DANIEL RAMKER, M.D.
LOWELL J. HILLIS, M.D.
NATHAN SALON, M.D.
PETER CLASSEN, M.D.
A. W. CAVINS, M.D.
THEODORE R. HAYES, M.D.
MRS. C. B. LADINE

Governmental Medical Services

Only one meeting of the Commission was held during the past year. This came about not for lack of needs, but really because of the gasoline shortage.

The February 20, 1974, meeting was very significant, in that it pointed out the communication difficulties within federal bureaucracies and between federal bureaucracies and providers such as ISMA represents.

Apparently in 1973, Immediate Past President James Gosman's testimony at the federal hearing in Indianapolis on July 24, 1973, concerning area designation of PSROs in Indiana, was either ignored, misinterpreted or not reported to the proper bureaucracies. The hearing was called on short notice, which required Dr. Gosman to respond quickly and without benefit of counsel from commissions of the House of Delegates.

This single example is one of many pointing to the need for restructuring the commissions and committees and their relationship to the House of Delegates, Board of Trustees and Executive Committee of ISMA. It would be helpful if the House and the Board would develop not only primary policies but also contingent policies. The contingencies could be developed in detail by a group of physicians in an ongoing structure. The contingencies should be concerned with technical considerations rather than political considerations. The findings and recommendations of physicians working on technical matters should not be ignored, nor filed for information; rather they should be acted upon, with the commissions directed to develop and implement worthwhile technical projects.

The Governmental Medical Services Commission has recommended specifically for the past two years that there be an accumulation of information concerning fees, relative value studies and coding systems for procedures and diagnosis. This information is basic for evaluating ongoing and upcoming statewide proposals such as HMOs, Medicare, Medicaid, and billing of private insurance claims,

either on an in- or outpatient service, and providing guidelines for our members to function effectively in this jungle of paperwork. While no specific resolutions can be offered at this time, it would be advisable, if restructuring occurs, to commission the unit of the new structure to develop these specific resolutions needed for implementation of data-gathering in utilization projects. The physicians chosen for these studies should be selected on the basis of interest and past experience, rather than on a purely geographical basis.

I wish to express my thanks to the members of the commission who served this year.

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Interprofessional Relations

Before reporting on the activities of the Interprofessional Relations Commission during the past year, I think it only fitting to comment on the results achieved by this commission at the close of last year under the chairmanship of Dr. Warren Coggeshall. As you will recall, the developmental stages of the Nurse-Physician Joint Practice Commission were reported in this column one year ago. Since that time, the Nurse-Physician Joint Practice Commission of Indiana has become a functioning reality. The 16-member (eight physicians and eight nurses) Joint Practice Commission has met several times during the past year and has adopted its own set of by-laws, has established numerous priorities, has received approval from the parent organizations—ISMA and ISNA, has received funding from those organizations and has begun consideration of several of the priorities it established. Thanks to the efforts of Dr Coggeshall, his commission members and the physician members of the Joint Practice Commission, we are well on our way to establishing a better and more professional working relationship between and among physicians and nurses.

The Interprofessional Relations Commission met on three separate occasions during the past year to initiate similar dialogue with other professions. To date, the commission has met with representatives of pharmacy, dentistry and law.

In discussing the potential for better interprofessional relations with the pharmacists, the commission discussed such problem areas as the abuses of PRNs (Prescription Renewed as Needed), multiple-line prescription blanks, prescriptions without a physician's signature, and the use of name stamps. Also discussed were Patient Medication Profile Record Systems and Prescriptions for Narcotic Drugs which are signed in advance by physicians leaving on vacation.

There was strong agreement from both the commission members and the pharmacy representatives that a better system of communication between the two professions needs to be established. More specifically, the accessibility of the physician to the pharmacist needs to be improved.

The meeting with representatives of the Indiana Dental Association also raised some areas of mutual concern between the two professions. The main area of interest to the dental profession was their future role or involvement in Professional Standards Review Organizations (PSRO). The dentists strongly expressed the feeling that dental personnel must be involved in the standard-setting and policymaking decisions regarding dental practice, particularly in hospital settings. Another item of mutual concern of the two professions was the entire area of federal and state legislation. Although a good working relationship between the two professions' staffs has been enjoyed in the past, it was felt by all that a closer, more unified approach to legislative matters will be increasingly important in the future.

In meeting with members of the legal profession, the commission found that the major areas of concern to both professions dealt with problems encountered in medical malpractice litigation. Although many of the problem areas discussed are being considered by the Medical-Legal Review Committee—a joint committee composed of members of the Indiana State Medical Association and the Indiana Bar Association—the commission still felt that there were areas which could be further developed by improved communications between the two professions.

It is the strong hope of the commission that these initial endeavors will be further developed in the coming months and years and will result in the formation of joint committees similar to the Nurse-Physician Joint Practice Commission in all areas of interprofessional relationship.

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Emergency Medical Services

The Commission on Emergency Medical Services met once during the year and discussed a number of matters, with most attention given to the Indiana State Medical Association's commitment to the passage of an emergency medical service law for Indiana.

As a result of the efforts of the Commission during 1973 and into early 1974 to accomplish the mission of such passage, the bill passed, resulting in the establishment of an Indiana Emergency Medical Services Commission, with John S. Farquhar, M.D., Fort Wayne, elected as chairman of the commission.

Philip K. Martin of Lafayette, director of the State Department of Traffic Safety and Vehicle Inspection, was named executive director of the commission by Governor Bowen.

Since the organization of the Governor's Commission, it has been vigorously directing its efforts toward setting up standards for the various areas of EMS throughout the state.

The Commission wants to make note of the fact that the Governor's Conference on Emergency Medical Services, which resulted in the passage of the legislation was largely brought about through the efforts of Drs. Farquhar and Suelzer and the ISMA commission.

Other areas of concern which the Commission discussed were the status of emergency telephone number 911, the possibility of introducing a paramedic bill into the state legislature, and training for emergency medical technicians.

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Legislation

Although the short (30 working days) second regular session of the 98th General Assembly will go down in history as having been a very uneventful and noncontroversial session for organized medicine in Indiana, it was a most exciting and productive session. Of the 697 bills which were introduced during this 1974 session of the General Assembly, only 159 were enacted into law. However, of the 697 bills more than 100 had a direct bearing on physicians and health care in the state of Indiana.

The Commission on Legislation carefully reviewed all of these bills at its meetings held prior to and during the session. In reviewing the bills the commission determined whether or not each bill pertaining to health care would be supported, opposed, or taken for information only. The meetings during the remainder of the legislative session after the closing date for bill introduction were used to review the progress of the bills through the legislative process.

Of the more than 100 bills which were monitored by the Commission on Legislation, 26 were enacted into law. It is safe to say that none of the 26 bills on health subjects which were finally enacted into law were opposed by the Indiana State Medical Association through the Commission on Legislation.

There were several major pieces of health legislation which were enacted into law and which were actively supported by the Commission on Legislation. A thorough recounting of these bills can be found in the June 1974 issue of the JOURNAL. However, a brief summary of those major bills is appropriate for this annual report.

S.B. 55—A Family Practice Residency Bill—was enacted into law and will provide $1,000,000 to be used in the establishment of additional family practice residencies throughout the state. S.B. 151—Emergency Medical Services Bill—was also enacted after many years of attempting to do so. This bill was probably the most significant piece of health legislation enacted in recent years. H.B. 1163—Medical Distribution Loan Fund Bill—This ISMA-written and supported bill provides for loans to medical students at the rate of $3,000 per year. $100,000 was appropriated annually for this loan fund.

The commission has met and will continue to meet throughout the interim between legislative sessions to develop a legislative program for the upcoming year. Several will be presented at the House of Delegates meeting in October for determination by the House regarding their introduction in the 1975 session of the General Assembly. One of the major pieces of legislation that the commission is currently working on is the revision of the Medical Practice Act. This bill will again be presented at the House of Delegates meeting in October.

As chairman, I would like to express my thanks for the hard work and cooperation of the members of our commission as well as the cooperation and interest shown by the legislative representatives in the various county medical societies. In addition, a debt of gratitude is owed to the many physicians who unselfishly gave of their time and energy to help support the passage of legislation favorable to quality health care and to oppose the legislation believed to be unfavorable.

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Medical Economics and Insurance

Throughout the year 1973-74, the Commission on Medical Economics and Insurance has primarily devoted its time to the ISMA insurance programs available to the membership. Currently there are four active programs—all have been implemented within the past few years; all are growing substantially; all are actuarially sound; and we have received almost no complaints on these programs. These programs are also available to corporations as well as the individual members and include: (1) Overhead Expense Plan, (2) Family Life Insurance Plan, providing protection up to $50,000, (3) Income Protection Plan, providing up to $4,500 monthly for disability, and (4) Cash Value Life Insurance Plan, which is available for those who wish to convert their ISMA Term Insurance Plan.

In addition, there currently is being offered an Excess Major Medical Plan (with either a $15,000 or $25,000 deductible amount) that provides a limit up to $250,000. Information on all of these programs is available through the ISMA office.

Additional progress has been made in the development of the Professional Liability Insurance Plan for ISMA members. As this report goes to press, the results from a survey conducted among ISMA members to determine their interest in such a program is being completed, and a supplementary report will be made at the annual meeting in October by the commission, the officers and the Board of Trustees. The action on this program followed the approval at the 1973 meeting of the House of Delegates establishing a for-profit corporation and the implementation and the approval by the officers and the Board of Trustees. It is hoped that this matter may be definitely resolved in the year 1974-75.

During the past year the Commission on Medical Economics and Insurance has considered many other problems. The following matters need special note:

A. Blue Shield.
   1. In accordance with previously expressed policy, the specific problems of individuals were referred to members of the Board of Trustees or to the Blue Shield Board members.
   2. It should again be brought to the members' attention that there does exist a mechanism whereby physicians' surgical assistants can be compensated by Blue Shield if the surgeon so indicates on his statement to Blue Shield and to the patient.

B. Standardized Health Insurance Claim Form. Although Blue Shield, Medicare, Medicaid and CHAMPUS have not approved the standardized form, the commission believed that this form should be adopted by all ISMA members in the future.

C. Workman's Compensation Insurance. This proposal for ISMA sponsorship was again proposed this past year. Due to the prevailing low premium rate and the types of coverage most physicians seem to prefer, sponsorship is not recommended. It is recommended that each physician review his insurance coverage to be sure he is protected in this area.

D. Insurance Coverage for the Newborn. The commission strongly recommends that appropriate legislation be drafted to present to the legislature to require the inclusion of this type of coverage in family policies.

E. PSRO. The commission was totally opposed to this concept and reiterates its previous position that medical peer review is the only acceptable method of review of medical activities.

F. Intern/Resident Disability Insurance. No acceptable program has been arranged to date, although negotiations are continuing.

G. Professional Liability Coverage Rates. As is well known to all ISMA members, the cost for this

coverage continues to escalate rapidly. There appear to be inconsistencies in the structures but definitive information has been difficult to obtain. This area will continue to receive close scrutiny by the commission.

H. Confidentiality of Medical Records. This is a matter of great concern both as to hospital records and records in the physician's office. The practice of a few physicians in permitting outside organizations to inspect, abstract and to even copy these records is of most concern. The commission recommends that this not be permitted under any circumstances. If the patient authorization is presented for such procedure, we believe the patient should be informed of the possible consequences of such acts. The commission also realizes there is a need for pertinent information to be supplied to insurance carriers and other agencies and believes that physicians should cooperate in these areas if proper authorization is obtained. The AMA is expected to have a model law prepared for study at the clinical meeting in 1974. relating to confidentiality of medical records.

I. Liaison has been established with several specialty societies which have an interest in economic and insurance matters. It is hoped this liaison will be continued in the future.

The commission wishes to express its thanks to the ISMA staff for the cooperation and help it has received in working with the commission during the past year.

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Medical Education and Licensure

The commission has held four meetings during the past year. Mr. H. F. Raffensperger was appointed Coordinator for Continuing Medical Education for the ISMA with the main responsibility for supervision of the new accreditation process. The Indiana State Medical Association has been awarded a full four-year accreditation by the AMA for establishing Category I credit activities for programs offered by Indiana hospitals and other medical organizations.

The Accreditation Committee of the commission has conducted a variety of surveys and has accredited during the past six months the following hospitals and meetings of societies:

St. Joseph Hospital, South Bend
Memorial Hospital, South Bend
Deaconess Hospital, Evansville
St. Joseph Memorial Hospital, Kokomo
Reid Memorial Hospital, Richmond
LaPorte Hospital, LaPorte

The commission will also survey and accredit the annual meeting of the ISMA.

In addition, all ISMA members who have successfully completed the requirements for the AMA Physician Recognition Award have had their participation certified with a special ISMA seal and will be issued new membership cards signifying distinguished membership in the ISMA.

The commission also was instrumental in the co-sponsorship of the annual ISMA Student/Faculty Retreat which was held in March at Terre Haute. Approximately 80 individuals were in attendance. The theme was "The Physicians and Their World in 1984." Workshops and panels debated controls on medical practice, organizational changes in health-care delivery, the financing of medical care, and changes in medical education. The full report of the Retreat will again be published in THE JOURNAL of the ISMA.

The meetings of the commission featured participation by Miss Kathie Meador, president of the Indiana University Medical Student Council, and Mr. David H. Moore, an officer in the Student AMA. The commission members heard a series of special reports which included the following:

"The Department of Family Medicine" by Dr. A. Alan Fischer, professor and chairman of the Department of Family Medicine at IUMS,

"The Regenstrief Institute for Health Care" by Dr. Raymond H. Murray, professor and chairman of the department of Community Health Sciences and director of the Regenstrief Institute,

"The Activities of the State Board of Registration and Licensure" and "A Discussion on the FLEX Examination" by Dr. Merritt Alcorn, outgoing president of the State Board of Medical Registration and Examination.

Members of the commission held a series of joint sessions with the Commission on Convention Arrangements in order to prepare the scientific program for Category I accreditation, to prepare a CME exhibit, and to share in the planning for the annual meeting.

The commission again began discussion of the Medical Practice Act, with Mr. McDermott and Dr. Bryan preparing a revision for discussion by the membership of the House of Delegates at the annual meeting.

The commission unanimously voted a resolution of appreciation for Dr. Merritt Alcorn's leadership over the past eight years as president of the Indiana State Board of Medical Registration and Examination. The commission also gratefully acknowledges the participation of the Woman's Auxiliary.

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Public Health

The commission held three meetings this year. Attendance was good and a number of subjects were dealt with:

(1) Regionalization of health departments. At each meeting this subject was part of the agenda. Dr. Andrew Offutt reported that progress was being made. Dr. Robert Yoho of the State Board of Health was invited to our meeting but was unable to make it. This subject has been of continuing interest to the commission for the last three or four years and will continue to be so.

(2) The Indiana State Board of Health coordinated Indiana Plan to Eradicate Certain Vaccine Preventable Diseases. The commission reviewed this plan and recommended that the ISMA Board of Trustees support it. The plan's long-range goals are to reduce to 10% the unimmunized or partially immunized children in each disease. The ISMA Board gave its approval to the Commission on Public Health and recommended that the staff of the ISMA notify all component societies of this action

in support of the Indiana State Board of Health plan.

(3) Locum tenens relief for physicians practicing in areas where doctors are scarce, in order to permit these doctors to attend meetings and have vacations, was discussed at length. The AMA serves as a clearing house for information on locum tenens. Interested physicians may contact the AMA for information.

(4) The commission received three AMA pamphlets on Health Outreach, Free Clinics and Health Care of the Poor. These pamphlets propose more lay staff for Outreach and to attend to the social and the economic problems of the patients. Free clinics would be manned by volunteer physicians. Apparently substandard health care is available to these groups. The consensus of the commission lay in a deep awareness of these problems and the recommendation for cooperation in achieving their solution.

(5) Health care in jails was discussed in connection with a compilation of standards and materials in the publication entitled *Health Care in Jails, Prisons and Other Correctional Facilities* jointly produced by the American Bar Association and the AMA. Note was taken of the need for awareness of problems generated by and pertinent to jail operation.

(6) The National Health Policy and Health Development Act of 1974 (H.B. 12053, Rogers, Fla.). This omnibus bill of 66 pages brazenly represents federal usurpation of activities reserved to the states pursuant to the Tenth Amendment. If enacted, this bill would effectively strangle agencies established by state law. The Commission on Public Health voted that H.B. 12053 be considered totally unacceptable and is rejected unequivocally.

(7) V.D. Program. The State of Oregon's program providing for reporting of laboratory findings, the establishment of a Governor's Task Force on Venereal Disease, and the operation of free clinics with provision of supplies therefor, was discussed. Comparison with the Indiana situation was made. Much concern was expressed regarding the VD situation in Indiana, especially in certain urban areas such as Lake County. The commission voted to produce (a) a letter suitable for mailing to all physicians to emphasize this situation and (b) information for the editor of THE JOURNAL of ISMA for his consideration.

(8) Hypertension Program. The commission concurred with the action by Dr. Joe Dukes, ISMA president, when he notified Dr. W. T. Paynter, Indiana State Health Commissioner, of ISMA's support for the Department of Health, Education, and Welfare's hypertension education program.

(9) Ear piercing in business establishments. The commission recommended to the Board of Trustees of ISMA that piercing of the ears by medically unsupervised and/or non-medical personnel may violate the tenets of the Medical Practice Act and thus place the public at undue risk. This position was approved by the Board of Trustees. Information from the Secretary of the State Board of Medical Registration and Examination later indicated piercing ears was indeed a medical procedure and subject to investigation by that Board.

(10) Traffic safety forms for physicial examination of truck drivers. The present physical examination forms for truck drivers is the only requirement these important drivers need for licensure and yet it does not reveal certain essential information about the driver, such as his use of alcohol, drugs, psychiatric treatment, or record of accidents. In the interest of traffic safety, the commission recommended that the Federal Department of Transportation and the Interstate Commerce Commission include a statement from an appropriate law enforcement agency as a part of the physical examination for truckers. Such a statement should detail any record of the applicant's past history of alcoholism, accidents, narcotic use or psychiatric disorders. Such a statement would be a licensure requirement.

(11) Rule S-1 of the State Department of Public Instruction. A letter from the Orthopedic Association of LaPorte County, Inc., on this subject was reviewed. They passed a resolution disagreeing with the requirement that for a child to be eligible for a program of special education, a physician needs to show some abnormal neurological findings. This letter was referred to the Maternal and Child Health Committee of ISMA.

(12) A number of miscellaneous subjects were noted and reviewed: the National Society for the Prevention of Blindness recommends silver nitrate for preventing ophthalmia neonatorum; that protection of the newborn's eyes is important in phototherapy; a program for medical orientation of lay driver licensure examiners; the National Cancer Society's program; booklets from the USEPA on health effects of environmental pollution; booklets on alcoholism; a plan of blood donations by relatives of recipients as practiced in the San Joaquin County Medical Society, Calif.; the procedure for handling medicines for the school child.

The chairman wishes to thank the many loyal commission members who attended meetings so faithfully and who gave of their time and mature judgment with good will and an interest in the welfare of ISMA and of the people of our state.

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Public Information

The Commission on Public Information met December 16, 1973, February 17, April 28, and June 2, 1974.

The major work of the commission was the development of a lay speakers' bureau which will represent the Association's attitude on current medical issues. The format and budget was approved by the 1973 House of Delegates. Through the speakers of the bureau, factual reports to the people should promote understanding of the positions held by physicians concerning many socioeconomic and political matters. To date, several acceptances have been received from individual speakers. Completely managed by the Hopkins Syndicate, so as to be efficiently implemented, they will be responsible for all the development of biographical data and pictures, coordination of assignments, and for feed-back reactions from the audience. Background materials on various subjects will be provided to the speakers; however, the planning of the format of their individual talks will be in accord with each one's particular style of delivery.

Carried over from last year are plans to circularize a detailed, but simplified, questionnaire concerning activities of Association members. This is now in the implementation stage.

Also, efforts are now being made to develop a system whereby publicity and other material channeled through the ISMA office can, in turn, be sent to physicians who are close to editors and publishers in the media industry throughout Indiana. The survey is now in process and will include the names of editors, TV and radio news managers, and the names of local physicians on familiar terms with these individuals. This data is to be accumulated in the ISMA files and periodically updated.

Another ongoing successful program initiated in 1973 by the commission is the circulation of the waiting room poster, periodically mailed to interested physicians, which emphasizes health information, socioeconomic facts, and medical policies and philosophies.

The commission again this year made selections for the journalism awards and for the Physician of the Year Award. These awards are to be presented at the ISMA annual meeting in October.

A pamphlet "You and Health Insurance," originally drafted by Dr. Ahler, member of the commission, was reviewed by the Commission on Medical Economics and Insurance and is now being finally edited for printing and distribution to Indiana physicians. The pamphlet is designed to clarify for the recipient of health services the role the physician represents and the responsibility of insurance carriers.

Tel-Med, a toll-free telephone medical information service of ISMA, having been initiated for Marion County and nearby areas in April 1973, was developed into a statewide operation. The caller has a choice of 211 tape-recorded messages. The program, in terms of public relations, has received widespread favorable comment.

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Special Activities

During 1973-74 the Commission on Special Activities met on two occasions.

The commission was assisted in its work by two subcommittees: the Rural Health Subcommittee chaired by Dr. Richard Hawkins and the Subcommittee on Evaluation of Commissions and Committees chaired by Dr. Richard B. Hovda. The work of the latter subcommittee is still in progress.

The Rural Health Subcommittee created an Ad Hoc Study Committee, chaired by Dr. Raymond Murray, which prepared a detailed proposal for an Assessment and Assistance Program to promote improvement in the availability and accessibility of health care services for underserved rural regions in Indiana. The proposal was submitted for possible federal funding as a joint project with the Department of Community Health Sciences, Indiana University School of Medicine and the Regenstrief Institute for Health Care, Marion County General Hospital.

The objectives of the Rural Assessment and Assistance Program are:

1) To procure, correlate and store the available information on health care and related subjects which pertains to rural areas in Indiana.

2) To work with rural regions which are medically underserved and which apply for assistance for improving their health care services.

3) To develop a suitable group of practicing physicians, physicians-in-training, other health providers and interested citizens with an interest and experience in rural areas. This group will provide assessment and assistance to the identified needy areas. In addition, this group will attempt to establish criteria for medical and auxiliary professional staffing in rural areas and norms for physical facilities.

4) To promote interest in rural medical practice among medical students and physicians-in-training.

5) To serve as a placement service for physicians-in-training who are interested in rural practice.

6) To evaluate the effectiveness of this program. To achieve these objectives there will be established a Special Action Committee for Rural Health (SAC) which will be created as a subcommittee of and responsible to the Rural Health Subcommittee of the ISMA.

The system will work as follows:

1) A rural town or rural area which has a serious need for improved health care will contact the ISMA or SAC. All contacts will be referred to the SAC.

2) After approval by the SAC, the interested town will be contacted and, with representatives of that town, a plan for assessment and assistance will be prepared.

3) The SAC will bring together from its own files and elsewhere all available information on that particular region, data which concerns health care resources as well as economic, demographic and related data.

4) The SAC will create a special Task Force for the assessment of this town, provide it with relevant information available on the town and the nearby area, and instruct the Task Force.

5) The Task Force will visit the region, meet with health care provider groups and other individuals and groups relevant to the study, and prepare a comprehensive report on the region's needs and resources. This will require an undetermined number of visits. The Program Director will probably also visit the community independently as well as with the task Force.

6) With the help of the Program Director, the Task Force will prepare and submit a final report to the SAC, and they will jointly prepare and submit an assessment and recommendation to the town and initiate whatever assistance seems appropriate and feasible. This will include advice, cooperation in preparing and carrying out surveys, serving as negotiators between or among dissident factions within the community, assistance with physician placement, etc.

7) The SAC will provide periodic reports on its activities to the Rural Health Subcommittee.

8) At a suitable time, following the completion of each project, the SAC (and perhaps also the special Task Force involved), will evaluate the effectiveness of this project.

HANUS J. GROSZ, M.D.
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MRS. JAMES GUTHRIE

Voluntary Health Agencies

The commission met four times during the fiscal year to conduct its business relating to the voluntary health agencies of Indiana.

After review of comprehensive reports submitted by the various agencies concerning their programs and activities, the following were given approval:

American Cancer Society, Indiana Division, Inc.
American Heart Association, Indiana Affiliate, Inc.
American Lung Association of Indiana
Arthritis Foundation, Indiana Chapter
Hemophilia of Indiana, Inc.
Indiana Easter Seal Society for Crippled Children and Adults, Inc.
Indiana Society for the Prevention of Blindness
Kidney Foundation of Indiana, Inc.
Mental Health Association in Indiana
National Multiple Sclerosis Society, Indiana Chapter
Tri-State Epilepsy Association, Inc.

Following the usual pattern of organization, 14 liaison representatives from the Woman's Auxiliary, headed by Mrs. Jack Walker of Yorktown, worked with the commission and the health agen-

cies of the state by attending meetings of the agencies and keeping abreast of their activities.

The commission, in conjunction with representatives of the state health agencies and the ISMA Woman's Auxiliary liaison members, had a very successful luncheon meeting in February. Much enthusiastic input was gained from the agencies regarding their new programs, the methods of evaluation, personal contacts, a proposed health agency booklet explaining agency purposes and services, and the new statewide Tel-Med program of ISMA.

In order to obtain more coordinated activities with the commission, three representatives from different agencies were appointed by the agencies to serve on a rotating basis as permanent non-voting members of the commission and are invited to all commission meetings.

Approximately 10,000 placards listing approved agencies were distributed this year and plans have been made to continue with the printing and distribution of placards for 1974. Additional plans are for the placard to be printed in THE JOURNAL and perforated so as to be easily extracted by physicians wanting to use it as a reference. This will be in addition to the usual listing of the approved agencies.

As examples of some of the commission's additional involvement with the agencies, the following items were considered:

The group investigated the Heart Disease Research Foundation headquartered in New York City and listed in the yellow section of telephone directories throughout the nation as accepting funds for research. Careful review of its income and expenditures was conducted and they were found to be questionable. Both the American Heart Association and the American Medical Association have incomplete data on the organization. The commission feels that contributions to this organization should be discouraged.

Additionally, the commission looked into the matter of one agency's circulating material to patients, causing some concern and consternation among physicians. In an excellent spirit of cooperation, this agency, the Multiple Sclerosis Society (one of the ISMA's approved bodies), agreed to mail the material direct to physicians.

The commission also voiced objection to the Board of Trustees of the ISMA for lending its name in support of a statewide program of an agency which was not on the approved list of organizations. The Board, after careful review of the situation, moved that henceforth it would be the policy of the Association to adhere to the recommendations of the commission concerning such support.

The commission wishes to emphasize to the House of Delegates the appreciation expressed by officials of the voluntary health agencies of the interest of the ISMA in their affairs. This, of course, is a two-way cycle with the agencies interested in the programs of the Association which in every instance affects one or more of them at any given time.

Finally, as chairman, I want to express my thanks to the members of the commission and to the agency representatives for making this past year's activities meaningful for all.

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(Chairman, Woman's Auxiliary Liaison)
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MRS. HAROLD R. WIREY

1974 Reference Committees

REFERENCE COMMITTEE No. 1
(Reports of Officers)

Thomas C. Tyrrell, Hammond (Lake), Chairman
Richard R. Eggers, Crawfordsville (Montgomery)
William R. Cast, Fort Wayne (Allen)
C. David Ryan, Columbus (Bartholomew-Brown)
Max N. Hoffman, Covington (Fountain-Warren)
Fred L. Toumey, Indianapolis (Marion)

REFERENCE COMMITTEE No. 2
(Constitution and Bylaws)

Thomas J. Conway, M.D., Terre Haute (Vigo), Chairman
Carl M. Porter, Jasonville (Greene)
Peter E. Gutierrez, Crown Point (Lake)
Rolla D. Burghard, Indianapolis (Marion)
Douglas H. White, Indianapolis (Marion)
John D. Wilson, Evansville (Vanderburgh)

REFERENCE COMMITTEE No. 3
(Miscellaneous Business)

Raymond H. Murray, Indianapolis (Marion), Chairman
John G. Pantzer, Jr., Indianapolis (Marion)
J. Franklin Swaim, Rockville (Parke-Vermillion)
James S. Robertson, Plymouth (Marshall)
George M. Haley, South Bend (St Joseph)
John A. Knote, Lafayette (Tippecanoe)

REFERENCE COMMITTEE No. 4
(Insurance, Medical Education, Special Activities)

Donald C. McCallum, Indianapolis (Marion), Chairman
Lloyd H. Hill, Peru (Miami)
Norbert M. Welch, Vincennes (Knox)
James T. Anderson, Greenfield (Hancock)
B. T. Maxam, Indianapolis (Marion)
Wallace S. Tirman, South Bend (St. Joseph)

REFERENCE COMMITTEE No. 5
(Legislation, Governmental Medical Services)

William F. Blaisdell, Seymour (Jackson-Jennings), Chairman
I. E. Michael, Indianapolis (Marion)
Nicholas Egnatz, Hammond (Lake)
Glen Ward Lee, Richmond (Wayne-Union)
Martin J. O'Neill, Valparaiso (Porter)
Kenneth L. Gray, Indianapolis (Marion)

CREDENTIALS COMMITTEE

William G. Bannon, Terre Haute (Vigo), Chairman
John O. Butler, Indianapolis (Marion)
Charles R. Thomas, Indianapolis (Marion)
Eugene S. Rifner, Van Buren (Grant)
Kenneth O. Neumann, Lafayette (Tippecanoe)

TELLERS

Robert M. Seibel, Nashville (Bartholomew-Brown), Chairman
Everett E. Bickers, Floyd Knobs (Floyd)

Resolutions

Amendments to the Constitution to Be Voted on at Indianapolis Session, 1974

At the 1973 annual convention at Indianapolis, the House of Delegates adopted the report of the Reference Committee in which the Reference Committee recommended for adoption the following amendments to the Constitution.

Article IV, Composition of the Association

Be It Resolved that Section 1 of Article IV be amended by striking the entire Section 1 as now printed and substituting the following:

Section 1. This Association shall consist of Active Members, Associate Members, Interns and Residents, Senior Members, Honorary Members, Disabled Members, Distinguished Members, Military Service Members, Public Health Service Members, Retired Members and members of the Indiana Chapter of the Student American Medical Association.

Be It Further Resolved that Section 4 of Article IV be renumbered Section 5 and that a new Section 4 be substituted to read as follows:

Sec. 4—Student Members.—Students who hold active membership in the Indiana Chapter of the Student American Medical Association shall have all the rights and privileges of this Association and shall select one delegate or one alternate delegate who shall have all the rights and privileges of the House of Delegates with the power to vote.

(Old Sections 5 through 8 to be renumbered 6 through 9)

Be It Resolved that Section 9 of Article IV of the Constitution be renumbered Section 11 and a new Section 10 be substituted to read as follows:

Sec. 10.—Military Service Members and Public Health Service Members.—Any physician who is actively engaged in the military service or public health service shall be eligible for membership in the Association with payment of reduced dues, they shall receive THE JOURNAL.

Be It Further Resolved that in addition to being renumbered Section 11, Section 9 of Article IV of the Constitution be amended to read as follows:

Sec. 11.—Rights and Privileges of Members.—Active members, intern and resident members, senior members, military service members, public health service members, disabled members, honorary members, student members and retired members shall have the same rights and privileges except as follows:

a. Senior members shall not be required to pay membership dues in the State Association.

b. If senior members desire to receive THE JOURNAL of the State Association, they shall pay the regular subscription price therefor.

c. Senior members who desire the benefit of medical defense as provided by the Bylaws of this Association shall pay the amount stipulated in Section 1, Chapter XXXIV of the Bylaws for this coverage.

d. Honorary members hereafter elected shall hold such membership as an honor and distinction and shall have the right to attend meetings of the Association. They shall have the privilege of participating in discussions but shall have no right to vote or to hold elective office. They shall not be required to pay membership dues in the State Association. Such honor may be conferred by the vote of the House of Delegates.

e. All such disabled members, as defined in Chapter IV, Section 9, shall receive membership cards and THE JOURNAL of the Association without charge.

f. Student memberships may be represented in the House of Delegates with all the rights and privileges and the power to vote. They shall be entitled to send one delegate or one alternate who are members of the Indiana Chapter of the Student American Medical Association. They are to receive THE JOURNAL of the State Association.

g. Retired members who have chosen voluntary retirement from the practice of medicine before the age of 70 shall only be required to pay membership dues in the amount of one half of the full membership dues applicable at the time of retirement.

Resolution No. 74-1

Introduced by: Vanderburgh County Medical Society

Subject: LEGISLATION TO DEFINE THE WORD "PHYSICIAN"

Referred to:

Whereas, Indiana courts have construed the word "physician" to include a person engaged in the practice of chiropractic; and

Whereas, The term "physician" is ordinarily understood by laymen to signify persons who are graduates of schools of medicine or schools of osteopathy; and

Whereas, The application of this term to graduates of schools of chiropractic is misleading as to both the amount and the quality of education of the practitioner; and

Whereas, The validity of the foregoing statements has been recognized by a formal endorsement of the Indiana State Medical Association House of Delegates in annual convention in October 1972 and again in October 1973; and

Whereas, The staff of the Indiana State Medical Association did subsequently seek to encourage members of the Indiana state legislature to redefine the legal meaning of the term "physician" through support of appropriate legislation; now, therefore, be it

Resolved, That the Indiana State Medical Association again prepare and seek to have introduced into the General Assembly a bill defining the term "physician" as applying only to persons holding the academic degree of Doctor of Medicine, or Doctor of Osteopathy.

Resolution No. 74-2

Introduced by: ST. JOSEPH COUNTY MEDICAL SOCIETY

Subject: COMPOSITION OF THE HOUSE OF DELEGATES OF THE ISMA

Referred to:

Whereas, The present Constitution of the ISMA in Article V, Section 1, states that the House of Delegates shall be the legislative and business body of the Association and shall consist of: (1) delegates, or their designated alternates, elected by the component county societies; (2) the trustees, or their designated alternates; (3) the ex-presidents of the ISMA, and (4) delegates, or their designated alternate delegates elected by their respective section. The following shall be ex officio members: the president, the president-elect, the executive secretary, the treasurer and the assistant treasurer of the Association, and the delegates to the AMA, all without power to vote, except in case of a tie, when the person presiding shall cast the deciding vote;

Whereas, The Constitution appears to intend that the House of Delegates of ISMA consist of members of ISMA elected to represent various component county societies or districts;

Whereas, The members of the House of Delegates of ISMA are elected by ISMA members of various component county societies and districts, except for officers of ISMA, who are elected by the House of Delegates, and the executive secretary;

Whereas, The president of the ISMA is elected by the House of Delegates and eventually will become an ex-president and, therefore, under the present Constitution of ISMA, will hold a life membership in the House of Delegates; a privilege denied every member, except another past president;

Whereas, The House of Deelgates of ISMA in 1973 had 156 voting members, including 16 ex-presidents, which represents 10.2% of the voting members of the House of Delegates of ISMA;

Whereas, an ex-president does not officially represent a component society or

a district of the ISMA, but only himself; therefore, be it

Resolved, That Article V, Section 1, of the Constitution of ISMA be amended to include the ex-presidents of the ISMA in the House of Delegates as ex officio members without power to vote.

Resolution No. 74-3

Introduced by: Marion County Medical Society
Subject: UNIFIED AMA MEMBERSHIP
Referred to:

Whereas, Experience has shown that medicine as a house divided is extremely vulnerable to those who would control physicians and their modes of practice; and

Whereas, Government inroads into the health care field are increasingly varied and bold; and

Whereas, A cacaphony of voices attempting to speak for medicine are unheard or dismissed as ineffective; and

Whereas, The American Medical Association, despite some shortcomings, unquestionably is the strongest influence in the national medical field and the only medical organization truly representative and effective on the national legislative scene; and

Whereas, American Medical Association programs and concerns touch upon practically every facet of medicine and its practice; and

Whereas, Only two county medical societies in Indiana, Marion and St. Joseph, require their members to be members of the American Medical Association; therefore, be it

Resolved, That the Indiana State Medical Association establish membership in the American Medical Association as a condition of membership in the Indiana State Medical Association and its component county medical societies.

Resolution No. 74-4

Introduced by: Marion County Medical Society
Subject: INCLUSION OF IMMEDIATE PAST PRESIDENT ON EXECUTIVE COMMITTEE
Referred to:

Whereas, The Executive Committee of the Indiana State Medical Association is the executive body of the Board of Trustees in the interim between meetings of the Board and frequently must make decisions for the Association; and

Whereas, The actions of the Committee represent a distillation of the wisdom, judgment and experience of its members; and

Whereas, It cannot be expected that any member of the Association could bring to the Committee more years of involvement with the affairs and problems of the Association than the immediate past president, who has been a member of the Board of Trustees, president-elect and president; and

Whereas, Inexperience is a luxury the Association cannot afford in these trying days; therefore, be it

Resolved, That Chapter VII, Section 12, of the Constitution and Bylaws of the Indiana State Medical Association be amended to provide that each immediate past president of the Association be a member of the Executive Committee, with power to vote, during the year in which he holds such title.

Resolution No. 74-5

Introduced by: Vigo County Medical Society
Subject: ISMA OFFICERS MANDATED TO OPPOSE PSROs
Referred to:

Whereas, The House of Delegates at the 1973 Indiana State Medical Association Convention voted unanimously to oppose the concept of PSRO and to work diligently for the repeal of the PSRO laws; and

Whereas, The delegates interpreted this vote as a mandate for elected and appointed officers of the Indiana State Medical Association to continue to act on their behalf until such time as a change was authorized by a called session of the House of Delegates; and

Whereas, The Board of Trustees of the Indiana State Medical Association rejected a government grant to form a support committee to study PSRO; therefore, be it

Resolved, That until such time as the official stand of the majority of the members of the Indiana State Medical Association, as expressed by the vote in the House of Delegates, be changed, that the elected and appointed officers of the Indiana State Medical Association be instructed to continue to follow that mandate; be it further

Resolved, That any officer or appointed official of the Indiana State Medical Association who associates him or herself with any group that is working outside the Indiana State Medical Association to obtain funds from the federal government to support a study of PSRO be asked to either publicly disassociate themselves from such a group or be asked to resign from their elected or appointed office in the Indiana State Medical Association; and, be it further

Resolved, That a copy of this resolution be sent to the headquarters of the Indiana State Medical Association, the Board of Trustees, and all county medical societies and also sent to the House of Delegates for action at the next state convention.

Resolution No. 74-6

Introduced by: Tippecanoe County Medical Society
Subject: PROTEST TO THE ACTION OF THE HOUSE OF DELEGATES OF THE AMERICAN MEDICAL ASSOCIATION
Referred to:

Whereas, The Reference Committee "A" 's Item 21 was not allowed to be discussed and not open to compromise or alterations; and

Whereas, There seemed to be pre-arranged planning to obstruct the democratic processes on the floor of the House of Delegates; and

Whereas, The AMA seems to be only willing to support PSRO and other governmental pet projects; therefore, be it

Resolved, That the ISMA actively recommends to the members of the ISMA that the members refrain from paying the American Medical Association dues for the year 1975, as a token of our disgust.

Additional resolutions appear on pages 855 and 869.

Want the Answers?

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PRACTICE MANAGEMENT WORKSHOP

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Subject: Appointment Scheduling and Telephone
Appointment Scheduling
Modified Wave Theory
Telephone
Selections from Video Cassette
Telephone Training Program for Medical Assistants

Subject: Physical Aspects of the Office

Subject: Personal Financial Planning
Insurance
Estate Planning
Retirement Programs
Net Asset Base (Significance of Net Gain as Opposed to Gross Income)

Subject: Paperwork Techniques
The Universal Insurance Claim Form
The "Big Ticket"

Subject: Legal Considerations
Malpractice Insurance
Informed Consent
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Legal Obligation to the Patient
Pension Reform
Privacy of Records

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Scientific Exhibits

W. P. Loh, Ph.D., M.D., Gary, Chairman

TAY-SACHS DISEASE: MODEL FOR THE PREVENTION OF GENETIC DISEASE

Exhibitor: Laird G. Jackson, M.D., Philadelphia

Co-exhibitors: Halley S. Faust
Larry R. Glazerman, B.S.
Philip Nimoityn, B.S.

Tay-Sachs disease is an inherited, neurodegenerative disorder, invariably fatal by the fifth year of life. It is transmitted as an autosomal recessive. Because of its occurrence in a limited population, namely Ashkenazic Jews, and because of the availability of methods to detect heterozygous adults as well as affected fetuses *in utero*, Tay-Sachs is presently the only recessive genetic disease amenable to mass carrier screening and complete prevention. Programs have been established to screen large populations for carriers of the Tay-Sachs gene, and these programs can serve as models for future attempts to prevent other genetic diseases.

USAF MEDICAL SERVICE

Exhibitor: United States Air Force
Medical Service
3503 USAFRG/ROS
Chanute AFB, Ill.

Attendants: Captain Gerald P. Benedict
or Major David G. Couser

The Air Force Medical Service exhibit depicts Air Force Medicine through illuminated print-parancies and Super 8 mm sound film.

THE PLASMA SCALPEL: A TOOL FOR BLOODLESS SURGERY

Exhibitor: John L. Glover, M.D., Department of Surgery, Marion County General Hospital, Indianapolis

Co-Exhibitor: William J. Link, Ph.D., Department of Surgery, Marion County General Hospital, Indianapolis

Attendants: John L. Glover, M.D.
William J. Link, Ph.D.
Leo R. Radigan, M.D.
Richard N. Smith, M.D.

The plasma scalpel is an experimental surgical scalpel which, with the generation of high temperature, ionized gas, has the capability of simultaneously incising and cauterizing tissue. This device has been developed in the Department of Surgery at Marion County General Hospital in cooperation with the School of Mechanical Engineering at Purdue University. The latest prototype of the plasma scalpel will be on display as well as a movie of it in use in various surgical procedures.

THORACIC OUTLET SYNDROME, EVALUATION AND MANAGEMENT

Exhibitor: Austin L. Gardner, M.D., Indianapolis

Attendant: Austin L. Gardner, M.D., Indianapolis

An exhibit on thoracic outlet syndrome consisting of a videotape of an interview with several patients demonstrating diagnostic and conservative therapeutic measures, and an evaluation of presenting symptoms and postoperative results will be presented.

X-rays, diagrams and posters will also be used to depict the various causes of the syndrome in about 20 patients.

The audiovisual department of St. Vincent Hospital filmed the interviews and aided in the preparation of the exhibit.

EPIPHYSEAL INJURIES IN ATHLETES

Exhibitor: Sports and Medicine Committee—ISMA

Co-exhibitor: Lafayette Orthopedic Clinic

Attendant: William B. Ferguson, M.D., Lafayette

This exhibit will demonstrate by slide-sound method some common and some not-so-common epiphyseal injuries seen in athletes. Some will be quite evident with usual x-ray examination while others will require special techniques in order to demonstrate the pathology.

PERCUTANEOUS COAGULATION OF THE TRIGEMINAL NERVE—A NEW APPROACH TO TRIGEMINAL NEURALGIA

Exhibitor: John M. Tew, Jr., M.D., and Frank H. Mayfield, M.D., Cincinnati

Attendants: John M. Tew, Jr., M.D.
Thomas Berger, M.D.
James Miller, R.N.

Although the technic of electro-desiccation of the gasserian ganglion for trigeminal neuralgia was introduced by Kirschner (Germany) in 1931, it gained few advocates in this country until Sweet proposed certain changes in the technic which eliminated objectionable complications. Since 1969, we have treated 200 cases of typical trigeminal neuralgia by this method. Initially, it was used only in those cases who, for various reasons, were not candidates for standard surgical procedures, retro-gasserian rhizotomy. However, our recent experience has led us to recommend this approach as the primary surgical procedure for patients in whom pain has not been relieved by drug therapy.

Previous experience indicates that permanent anesthesia of the face is not necessary for long-standing relief of trigeminal neuralgia. Accordingly, it is the objective of this technic to produce controlled hypalgesia in the distribution of the trigeminal nerve responsible for the painful disorder. It is presumed that accurate control of the temperature generated by radio frequency current permits a selective lesion of small C fibers and leads to permanent hypalgesia, yet preserves light touch, proprioceptive sensation of the face, and motor function.

In this exhibit we wish to describe the technic and show a movie (sound with earphones) which will demonstrate the technic. Results in 200 cases will be reported.

THE COMPREHENSIVE CARE OF CERVICAL SPINE INJURIES

Exhibitor: John M. Tew, Jr., M.D., Cincinnati

Co-exhibitors: G. James Sammarco, M.D.
Frank H. Mayfield, M.D.
Nicholas J. Giannestras, M.D.
Emily R. Hess, M.D., Cincinnati

Attendants: John M. Tew, Jr., M.D.
James Sammarco, M.D.
James Miller, R.N.
Thomas Berger, M.D.

Recent advances in the comprehensive care of individuals suffering from frac-

tures of the cervical spine are illustrated in this exhibit. In particular, we wish to demonstrate the value of active cooperation between members of a team consisting of individuals involved in emergency medicine, neurosurgery, orthopedics, and rehabilitation medicine, all valuable and active members of the spinal injury team.

Comprehensive care of the spine-injured patient begins at the moment of the accident. It involves and consists of early diagnosis and proper transportation to a center capable of administering total care to the potentially injured patient.

Specific technical advances which have been employed by this team include: early reduction and fixation of fractures by operative and non-operative means, stabilization of fractures by internal operative methods and external immobilization by the new halo-plaster technique. Using this method, it has been possible to avoid the long periods of skeletal traction (6-10 weeks) required in previous years. During this period of active healing the fracture patient may begin physiotherapy and gait training in order to escape the ravages of long bed rest resulting in muscle wasting thromboembolism and emotional depression. The proven value of active physiotherapy in preparation for return to a previous or new occupation will be stressed. Technics of diagnosis, treatment and rehabilitation will be illustrated.

EFFECTS OF RADIATION ON INDUCED MEDULLOBLASTOMAS IN HAMSTERS

Exhibitor: Robert E. Shupe, Ph.D., Director of Radiation Biology, Department of Radiation Therapy, Indiana University School of Medicine, Indianapolis

Co-exhibitors: Ned B. Hornback, M.D. and Tue T. Chen, Ph.D., D.V.M., Indiana University School of Medicine, Indianapolis

Attendants: Robert E. Shupe, Ph.D.
Ned B. Hornback, M.D.
H. Shidnia, M.D.
S. Drake, R.T.

The exhibit depicts by means of charts, photographs and specimen samples, the development of the hamster medulloblastoma, the procedures utilized in implantation of the tumor into the experimental animals and the experimental procedures designed to test the results of fractionated radiation doses delivered to the primary tumor site and possible sites of tumor metastasis.

The study will consist of three groups of animals, (eight animals per group). All animals will receive tumor implants into the brain. Group I—no treatment, Group II—total brain irradiation, Group III—total brain and spinal irradiation. The results of the radiation may be evaluated by contrasting the length of survival between the three groups of animals.

HELPING IN THE DELIVERY OF HEALTH CARE

Exhibitor: Regenstrief Institute for Health Care, Marion County General Hospital, Indianapolis

Attendants: Robert W. Mouser, M.D., Raymond H. Murray, M.D., Stephen D. Roberts, Ph.D., Mary Ann Michau, R.R.A., Shirley Ross, R.N., Robert Chevalier, M.D., James P. Reber, M.H.A., Richard A. Laird, M.H.A., Martha Gannon, Danny P. Fox and Mae Dorminy.

The Regenstrief Institute and the Department of Community Health Sciences of the Indiana University School of Medicine, located on the grounds of the Marion County General Hospital, present

"HELPING IN THE DELIVERY OF HEALTH CARE"

for you, Doctor.

We hope you will visit us to find out what we are doing to help make your job easier. We also welcome your ideas and suggestions as to how health care delivery affects you.

TUMOROPHILIC GALLIUM-67 LOCALIZATION

Exhibitor: Eugene D. Van Hove, M.D., Methodist Hospital, Indianapolis

Co-Exhibitors: Larry L. Heck, M.D.
Jerry Kight, M.D.
Reginald Bruce, M.D.

Attendants: Eugene Van Hove, M.D., Larry Heck, M.D., Jerry Kight, M.D., and Reginald Bruce, M.D.

A new method to help stage malignant tumors will be shown.

The procedure is safe, simple, and can be done on an outpatient basis. Over 500 cases have been done in Nuclear Radiology at Methodist Hospital in the last three years.

Examples of benign and malignant tumors will be shown as well as inflammatory lesions.

The usefulness of this study in lymphomas, especially Hodgkins Disease, and in carcinoma of the lung will be stressed.

THE CASE FOR EN BLOC CADAVER NEPHRECTOMIES

Exhibitors: John P. Donohue, M.D. and Laurence J. Gott, M.D., Department of Urology, I.U. Medical Center, Indianapolis

"The Case for En Bloc Cadaver Nephrectomies" presents a video-tape movie demonstrating the en bloc technique for removal of cadaver kidneys for use in transplantation. Using animation, a model demonstration and actual cadaver surgery, the film covers the concept of brain death, common pitfalls of all cadaver nephrectomies and the actual en bloc nephrectomy technic.

THE CORONARY VEIN GRAFT OPERATION

Exhibitor: Cardiovascular Surgeons, Inc.
1815 N. Capitol Ave.
Indianapolis

Co-Exhibitor: Methodist Hospital, Indianapolis

Attendants: Harold Halbrook, M.D., and Pam Linden, R.N.

Exhibit will show data pertaining to vein graft operations as it relates to immediate intermediate and long term results.

ADDITIONAL

TECHNICAL EXHIBITORS — 1974

AMES COMPANY
DIVISION OF MILES LABORATORIES, INC.
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For further information on this subject, the following references are provided:

1. Henry BW, *et al: Dis Nerv Syst 30*:675-679, Oct 1969.
2. Hollister LE, *et al: Arch Gen Psychiatry 24*:273-278, Mar 1971.
3. Claghorn J: *Psychosomatics 11*:438-441, Sept-Oct 1970.



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Letter to the editor

To the editor:

As suggested in your recent letter, while in Scotland I looked into the State Medicine issue. It was boiling while I was there. One of the unions (hospital employees below the level of nurses) gave an ultimatum: they refused to service hospital wards earmarked for private practice. These beds had been set aside for consultants to do part-time private practice. There is a shortage of hospital beds (elective hospitalization delay is approx. three-six months), and the Labour Party now in power has a stated policy to phase out private hospital practice —date not set. Consultants are furious. Their compensation is not in line with their responsibility. (Their privilege was some sugar-coating granted in past). They allege that if their beds are phased out, they will work strictly by the hour, as their contract specifies, and meantime 50% of hospital consultants are looking into migrating: to Canada, Australia, Rhodesia, U.S.A., etc.

The house staff Registrars (fellows, or long-term residents) are restless, too. No Registrar can hope to become a Consultant, no matter how well qualified, until a Consultant's slot is emptied by death or removal. Meantime they can stay on for 10 years or more, at less income than the General Practitioner.

The General Practitioners are unhappy too. They have *no* hospital privileges except for obstetrics. Elective hospitalization is 3-6 months delayed. Their income has allegedly not kept pace with that of M.D.s in Scandinavia, West Germany, Netherlands. The younger ones are thinking of emigrating. A friend in Lincolnshire is head of a group of four G.Ps. They have a panel of 13,000. They would like another associate, but can only get someone not congenial to the patient panel, so will "rub along" as best they can.

The patients like the system. Most of them have better medical care than ever before. The state is lavish in hearing aids, wheel chairs for strokes (and home modifications if needed) and does provide all sorts of medical facilities, although the more sophisticated maybe in only one or two places in Scotland. Specialization is somewhat cramped by the fact that limited (none, soon?) hospital facilities exist for private surgery, and office practice will attract the few who don't want a panel, and who, taxed to provide panel health coverage, can still afford a private M.D.

I conclude: for the general run of patients, panel medicine is better than ours. The tide in U.S. is to some form of state medicine. If we stubbornly oppose any and all suggestions of change, we shall be following blindly the footsteps of the B.M.A. of years ago, and will deserve to land in the same mess they have created.

Sincerely,
Roger A. Hemphill M.D.
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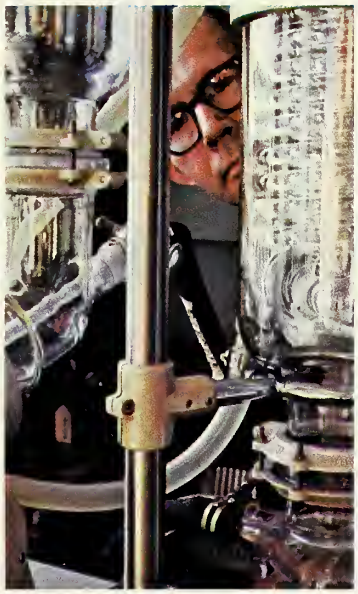
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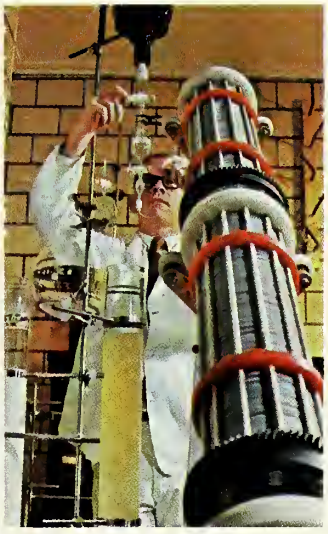
















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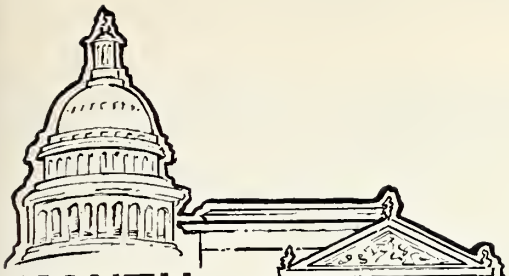
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MONTH IN WASHINGTON

This summary of what is happening in Washington is prepared by AMA's Capitol office and air-mailed to The Journal on the first of each month preceding month of issue.

Congress's on-again-off-again attempts to write a national health insurance law are very much off again—so far off that most observers believe there is no chance whatsoever for the 93rd Congress to go down in history as the author of mandated health insurance for all.

The method of financing NHI was again the stumbling block, cutting the House Ways and Means Committee down the middle in a 12-to-12 vote (a tie vote defeats an amendment) and thus scuttled a patchwork proposal by Chairman Mills that seemed to many likely to win Committee passage.

The dramatic tie vote came about the morning of Tuesday, Aug. 20, after the Committee had been called to order by Chairman Mills with the admonishment "We need to work awfully hard."

Staff began to explain the draft compromise point by point in routine fashion to the Committee when Rep. Joel T. Broyhill (R-Va.) said he believed the Committee should be given the opportunity to vote on alternate methods of financing NHI (as opposed to the Social Security payroll tax), such as the tax credit idea in the AMA Medicredit plan. Mills stalled Broyhill off until the financing section of the compromise regarding mandated employer coverage was completed. The Chairman was about to go on, when Broyhill again reminded Mills that he wanted a vote on his amendment. The AMA tax credit approach would be voluntary and consistent with the free enterprise system, Broyhill said.

The first roll call vote of the Committee defeated the Broyhill proposal 11 to 10. One member—Rep. Bill Archer (R-Texas)—changed his vote from "present" to "aye" and the motion was tied. Rep. Charles Chamberlain (R-Mich.) walked in and the proposal was ahead 12-11. However, Rep. Herman Schneebeli (R-Pa.) showed up to cast a "no" vote and the tie 12-12 tally defeated the Broyhill proposal.

Though not apparent at the time, this was the beginning of the end. Rep. Omar Burleson (D-Texas) lost 13-12 on his bid to substitute the financing proposed by the health insurance industry's NHI plan. The crusher came at the afternoon session when the Committee aproved 11 to 7 a motion to make voluntary rather than mandatory the compromise provision for the poor and the self-employed. This was a drastic setback for Mills who angrily adjourned the hearings until the next day.

The following morning shortly after the Committee had convened, Chairman Mills threw up his hands, saying: "I've never tried harder on anything in my life. But we don't have it. I'm not going to go before the House with a NHI bill approved by any 13-12 vote." He said the staff should try to figure out a different approach, but indicated he believed chances of reaching a future agreement on NHI were dim.

The forced abandonment of his compromise plan was a bitter defeat for Mills and for the Administration which had been working closely with the Chairman to steer a measure through the Committee. President Ford had urged Congress to give NHI top priority this year.

The up-and-down fortunes of NHI, which appeared to have a bright chance of passage following Ford's plea and Mills' determined push for a compromise, have now slumped to the point where only some drastic intervention by President Ford could save the measure for this year.

NOTE: Votes for the Medicredit financing plan came from Democratic Representatives Phil Landrum (Ga.), Richard Fulton (Tenn.), Omar Burleson (Texas), Sam Gibbons (Fla.) and Joe Waggonner (La.). On the GOP side, the pro-Medicredit votes were Representatives Broyhill (Va.), Jerry Pettis (Cal.), John Duncan (Tenn.), Donald Brotzman (Colo.), Donald Clancy (Ohio), Bill Archer (Texas) and Charles Chamberlain (Mich.).

Keogh Plan Liberalization to Be Retroactive to July 1, 1974

Self-employed physicians are about to receive some cheery news from Washington.

The House and Senate have passed and sent to the White House a liberalization of the Keogh law providing tax deferrals on retirement savings of self-employed people.

This means that physicians in this category can immediately start setting aside more money subject to tax deductions in qualified retirement programs. The bill's

Continued

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Keogh plan arrangement is retroactive to July 1, 1974.

There is no threat of a Presidential veto to cast any shadow on the legislation becoming law.

The bill substantially boosts the savings subject to tax deductions. The present Keogh plan allows the self-employed to set aside tax free up to 10% of their annual income with a $2,500 a year maximum. The new law will allow 15% of earned income, not to exceed $7,500 a year.

House and Senate conferees after months of work finally agreed on all provisions of a sweeping pension reform bill that contains the Keogh provision. The measure had earlier swept through both House and Senate with only minor opposition to the Keogh provisions.

Organized labor had fought the liberalization as a loophole for wealthier people, but many of labor's staunchest backers, including Rep. Martha Griffiths (D-Mich.), disputed labor's stand and supported the provision.

The liberalization capped a long fight by the American Medical Association for tax treatment of the self-employed physicians that would give them the same tax incentives for retirement savings as are now present in most corporate pension plans.

The bill also contains a relatively minor restriction on corporation pension plans that would affect so-called professional corporations that have been gaining favor with many physicians in recent years because of the more attractive retirement tax treatment. Tax deferrals will not be allowed on savings that would exceed a pension that brings in more than 75% of highest earnings over a three-year period with a maximum potential retirement income of $75,000 the limit. A "grandfather clause" exempts current plans that exceed this standard.

The new Keogh provisions plus a new Keogh-type plan for non-self-employed not covered by company pensions is expected to cost the government about $500 million a year in lost revenues.

In urging approval of the plan, Rep. Al Ullman (D-Ore.), second-ranking Democrat on the House Ways and Means Committee, told the House that "what we have to do is to bring into balance as much as we can the tax treatment for the self-employed as compared to the corporate community."

Retired Military Physicians May Now Retain Retirement Pay While Working for Pentagon

Retired military physicians may now accept positions as active physicians with the Defense Department without any loss of their retired pay. Defense hopes the exception to previous Civil Service Commission standards will induce retired military physicians to go to work for the Pentagon as civilian employees to help ease the shortage caused by the end of the military "doctor draft."

Mandatory Service and Relicensing Provisions in Bill approved by Senate

The Senate Labor and Education Committee has approved a revolutionary medical education bill that would require all medical graduates to serve in shortage areas and compel relicensing of all physicians.

The measure, written by the Health Subcommittee headed by Sen. Edward Kennedy (D-Mass.), carries almost $1 billion in federal aid for medical and other health schools over the next five years.

In addition to the controversial mandatory service and relicensing provisions, the bill gives the federal government power to allocate and limit postgraduate training positions for physicians. Designed to curb reliance on foreign medical graduates and to increase the numbers of primary care physicians, the disputed provision also requires the Secretary of Health, Education, and Welfare to limit the number of postgraduate physician training positions to no more than 10% above the number of domestic medical and osteopathic school graduates that year. The HEW Secretary would assign the total number of certified positions established to the various categories of specialty and subspecialty practice of medicine.

The Association of American Medical Colleges and the AMA were sharply critical of these provisions. The legislation now before the House Health Subcommittee is not expected to contain them. Eventual fate may hinge on the outcome of a House-Senate conference.

Chiropractic Services Covered by Medicare Limited

The government issued final regulations defining the conditions under which Medicare will help pay for services provided by independent physical therapists and limited services by chiropractors.

Under the regulations, carrying out the Medicare amendments law of last year, covered chiropractic services are limited to manual manipulation of the spine to correct "subluxations" which can be demonstrated by x-ray. Also, chiropractors must meet strict educational and professional requirements before their services can be reimbursed under the program.

The cost of x-ray will not be covered. HEW said the x-ray must demonstrate "at least . . . a malpositioning of a vertebra" identifiable by any experienced x-ray reader.

AMA Supports Limiting Inclusion of Vitamins and Minerals in Dietary Supplements

The American Medical Association has opposed legislation that would eliminate the authority of the Food and Drug Administration to control the kinds and amounts of ingredients in dietary supplements and other foods for dietary uses.

Appearing before the Senate Health Subcommittee, AMA officials noted that excessive use of vitamins can

Continued

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be harmful and is scientifically unwarranted. Combinations of vitamins should contain only those vitamins shown to be essential in human nutrition.

The witnesses were C.E. Butterworth, Jr., M.D., Chairman of the AMA's Council on Foods and Nutrition, and Vice Chairman Theodore Van Itallie, M.D. "There is no valid evidence to demonstrate that larger amounts of nutrients are beneficial under ordinary psychological conditions," said Dr. Butterworth.

Recent FDA regulations limiting the inclusions of certain vitamins and/or minerals in dietary supplements have aroused the wrath of food-vitamin faddists and prompted introduction of legislation to overturn the FDA's actions.

Restriction of FDA's powers in this field, the AMA officials told the Subcommittee, "would permit an unchecked proliferation of health deception and economic fraud."

Assignments for Medicare Patients Decline

Fewer than half of the nation's physicians are now accepting assignment for all their Medicare patients, according to the latest government figures. Deputy Assistant HEW Secretary Stuart Altman revealed the decline in testimony before the House Ways and Means Committee on national health insurance. HEW Secretary Caspar Weinberger later told the Committee a NHI program should carry inducements for physicians to accept the assignment route, but opposed making it mandatory.

President Ford Meets with AMA Officials

President Ford met with American Medical Association officials at the White House the end of August.

They discussed prospects for national health insurance in the current session of Congress and an AMA delegation's recent visit to China.

Those who attended the White House meeting included AMA President Malcolm Todd, M.D.; Richard C. Palmer, M.D., Chairman of the Board of Trustees; Russell Roth, M.D., Immediate Past President; Max H. Parrott, M.D., President Elect; James Sammons, M.D., Executive Vice President Designate, and Joe Miller, Assistant Executive Vice President.



"Journal of the Indiana State Medical Association — J-O-U-R-N-A-L O-F T-H-E . . . ."

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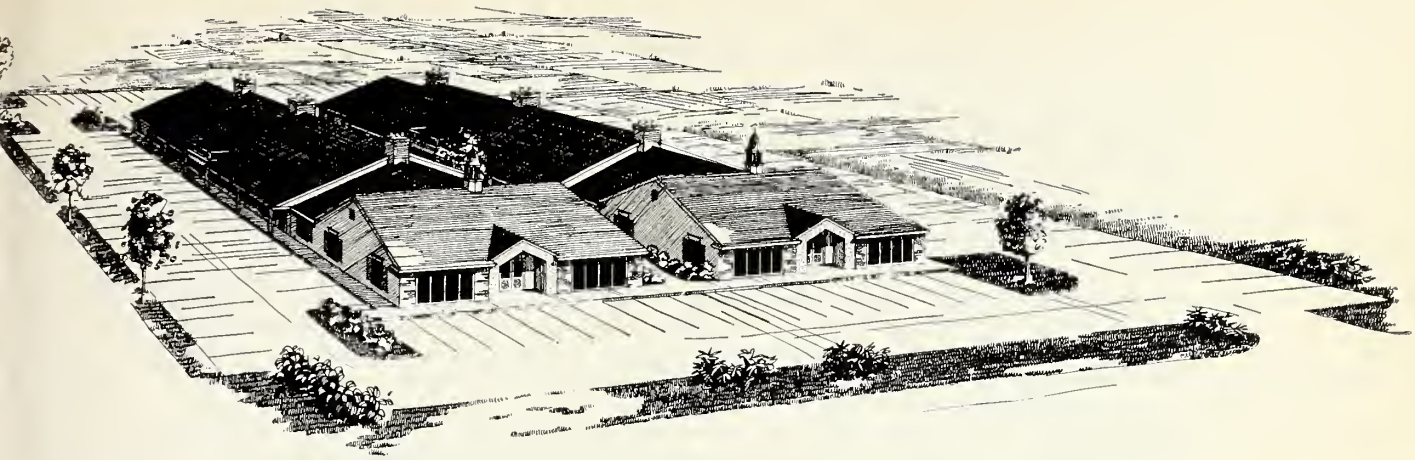
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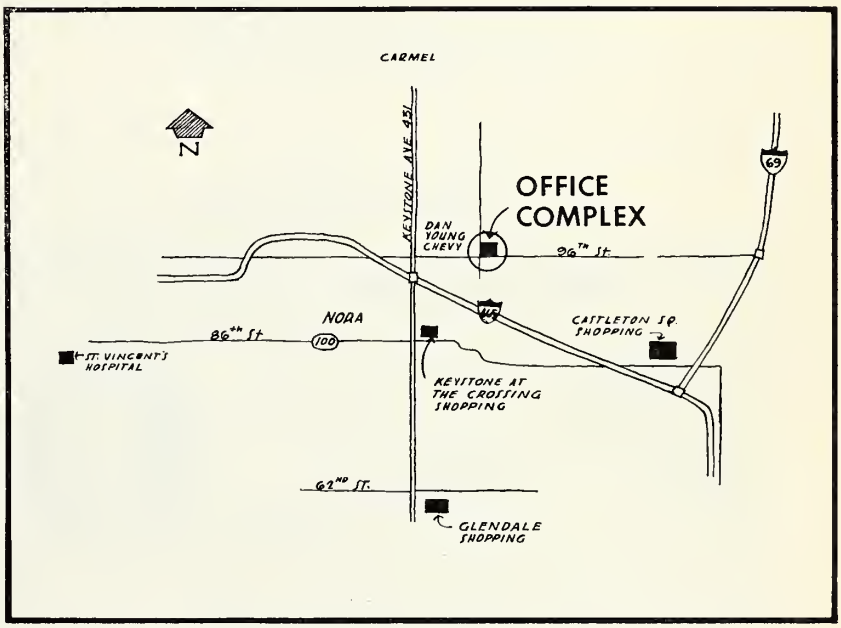
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From THE JOURNAL 50 Years Ago

I have never observed a case of cancer in which there had not been some pre-existing instability of the tissues, and a long continued irritation. It would seem as if the long suffering tissues respond to the chronic insult of the injury by supplying for repair cells less and less mature, until finally, through sheer inability to supply sound cells to heal the lesion, the tissues reach a stage in which there is uncontrolled production of unsound cells, too immature to heal the breach of continuity, or to furnish surface protection to normally protected tissues.

Admitting that we do not know just why chronically irritated tissues fail to repair their damage completely, we are by no means convinced that cancer is dependent on an external agency in the general nature of a living organism, bacterial or protozoal. The stumbling block to this belief in a parasitic agency is the fact that when malignant cells travel through the lymphatics, or through the vascular system to a distant organ, it is not the type of cell of the new host that develops, but the type of cell of the organ in which the cancer originated. When, therefore, cancer metastasizes from the stomach to the liver or the lungs, the new growth is a cancer of the stomach, in a different situation, which has converted to its own use, so to speak, the nourishment of its host; it is in no sense a cancer of the lung or of the liver. One would reason that, if the causative agency of cancer is something outside the body, then when this agent is carried to the liver, lungs, or other tissues, it would cause cancer of these tissues. . . .

The bipolar hypothesis of Crile is one of the latest with regard to the causation of cancer. Crile postulates that the nucleus of the cell is the positive pole, and the cytoplasm the negative pole, but we are left in the dark as to what disturbs the electric mechanism.

In any event, the cancer cell itself acts as the parasite. . . . William J. Mayo, M.D., Rochester, Minn., "The Influence of Ignorance and Neglect on the Incidence and Mortality of Cancer," **JISMA**, October 1924.

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androgenic deficiency



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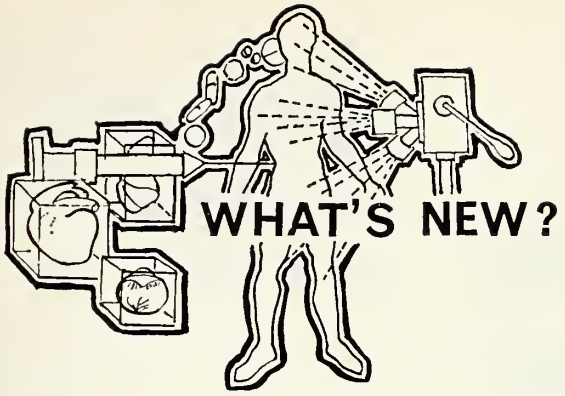
DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Postpuberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250.

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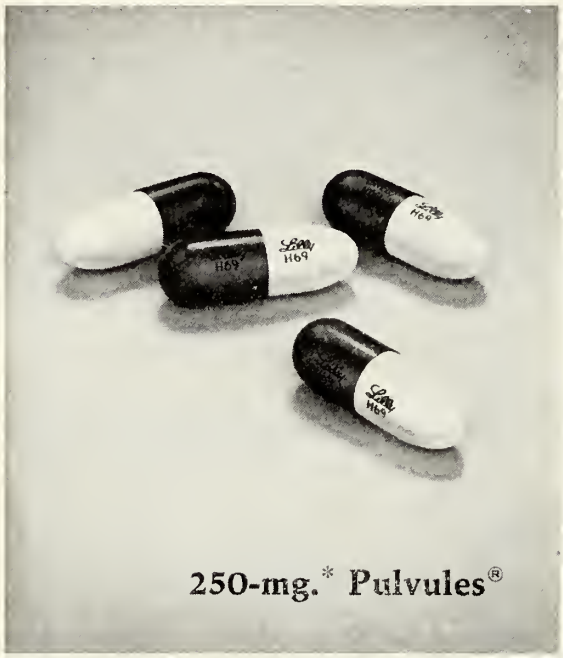
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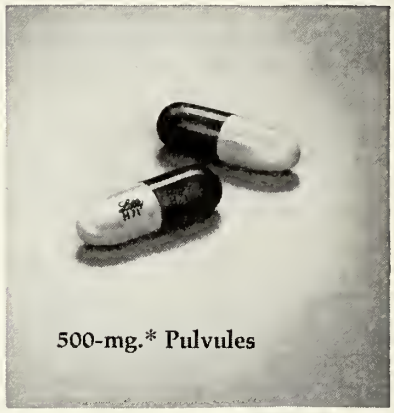
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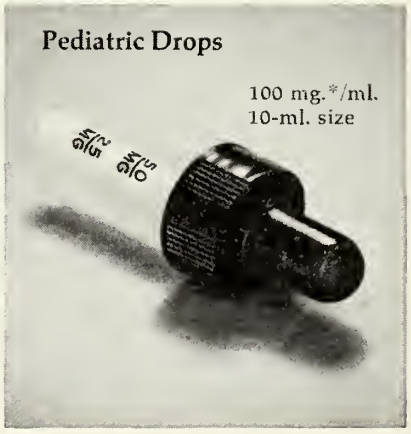
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Volume 67—October 1974—Number 10

Atrial Myxoma: A Curable Disorder — A Case Report

R. E. EDMANDS, M.D.
R. E. LINBACK, M.D.
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C. M. WUNSCH, M.D.
Indianapolis

PRIOR to the past decade, atrial myxomata were largely considered a pathological curiosity and diagnosable almost solely post-mortem or by happenstance surgical encounter. The means of antemortem detection of this tumor have been provided, however, both by the advent of cardiac catheterization with cineangiographic techniques and by echocardiography. The more felicitous aspect of this latter capability lies in the fact that atrial myxoma is amenable to surgical intervention. Moreover, surgical excision of this histologically benign tumor provides an almost certain cure for a disease that, left untreated, is almost certainly lethal.

The purpose of this report is to present a case which epitomizes the protean, systemic manifestations of this curious disorder. The auscultatory and hemodynamic features leading to the clinical diagnosis will also be discussed as well as the dramatic relief afforded by surgical intervention.

Case Report

The patient, a 25-year-old, Gr 0, P 0, white housewife had been well prior to 8-71 when she experienced the first of several urinary tract infections, recurrent over a period of nine months. Over this latter interval she also complained of recurrent painful mottled, macular rashes involving the hands and feet, occurring in a cyclical, migratory fashion, q 2-3 weeks. She first noted exertional, 2-flight dyspnea and palpitations five months prior to hospitalization in 5-72. Increasing pallor, fatigueability, and intermittent low grade fever (99.5 to 100.5) also were noted over the ensuing five months. A non-productive, increasingly intractable cough, worsened in the recumbent position, occurred over a period of three weeks and ultimately forced her to seek medical attention. A chest film taken at that time revealed a normal sized heart with moderate prominence of the pulmonary outflow tract. Prominent, cotton wool-like densities of uncertain origin were present bilaterally in the perihilar areas. She was then hospitalized (5-18-72) for further evaluation.

Physical examination at that time revealed a well-developed, well nourished (though somewhat pallid) white female who was quite apprehensive and distressed by protracted bouts of non-productive coughing, aggravated in the supine position. The blood pressure was 110/70 in both upper extremeties. The pulse was 120 to 140 per minute, essentially regular, and the respirations were 28 per minute. Pertinent physical findings included the following: While the jugular veins were not distended, prominent A waves were observed at 30 degrees elevation. Carotid pulses were present and equal, without bruits. Chest and lungs were clear to percussion and auscultation. The precordium was relatively quiet. A normal apical impulse was present in the fifth intercostal space within the midclavicular line. A moderate left parasternal lift was present. S-1 was not accentuated while splitting of S-2 was not appreciated. A loud early diastolic sound was heard ca. 0.10-0.12 seconds after S-2 at a time when one might anticipate an



Figure 1
Pulmonary edema is apparent in this preoperative PA chest film. Of pertinence is the normal sized heart as well as some prominence of the pulmonary conus.

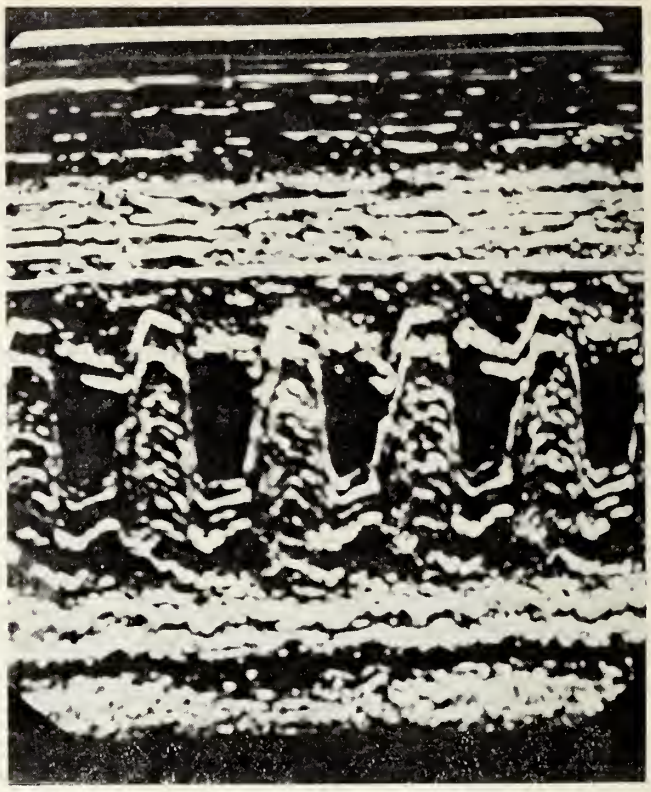


Figure 2
This preoperative echocardiogram exhibits the classical features of atrial myxoma. During diastole, the anterior leaflet of the mitral valve moves anteriorly (upward in the figure). Beneath (or posterior to) this echo can be seen the laminar echos from the myxoma which at least partially occludes the mitral orifice.

S-3 sound (consonant with the peak of rapid early diastolic filling). The latter sound was succeeded by a short diastolic rumbling murmur (and with presystolic accentuation at a subsequent, slower heart rate). The result of examination of the abdomen and extremities was unremarkable, as was the remainder of the physical examination.

Laboratory Data

WBC: 15,000; 72% neutrophils, 2% bands, 19% lymphocytes, 4% monocytes, 2% eosinophils. Hgb: 10.9 grams %; Hct: 33.9%. Serology was nonreactive. Serum glucose, 110 mgs %; BUN, 12 mgs %; cholesterol, 191 mgs %, alkaline phosphatase 33; SGOT, 122; calcium, 9.2 mgs %; phosphorus, 3.4 mgs %; total bilirubin, 9.4 mgs %, uric acid, 7.2 mgs %, total protein 7.3 grams %. Protein electrophoresis revealed a total protein of 7.2 grams % with albumin of 3.0 grams % and total globulin of 4.2 grams %. There was slight elevation of alpha I (0.5 grams %) and alpha II (1.5 grams %). Beta and gamma globulin determinations were normal. An electrocardiogram revealed a sinus tachycardia with a normal axis and no suggestion of either left atrial hypertrophy or right ventricular hypertrophy. Admission chest film is illustrated in Figure 1. A preoperative echocardiogram performed on the day of admission illustrates the classical echocardiographic signs of left atrial myxoma (Figure 2). A preoperative right heart catheterization revealed the presence of pulmonary artery hypertension (86 mm hg systolic) and an angiogram performed in the course of the catheterization revealed the presence of the left atrial myxoma.

Given 100 mgs of Lasix orally, the patient experienced a diuresis of six pounds within 24 hours with dramatic relief of her symptoms. Open heart surgery was performed on the fifth hospital day and the left atrial myxoma was removed (Figure 3) in a 12-minute interval during which circulation was maintained by the heart-lung machine. Her postoperative course was uneventful. An echocardiogram repeated on the sixth postoperative day revealed a normal mitral valve echo with no extraneous echos (Figure 4). Now sixteen months postoperative, she is completely symptom free and her chest film is within normal limits (Figure 5).

Discussion

The advent of means by which atrial myxoma can be diagnosed antemortem has led to the detection of this disorder with increasing frequency. While only 16 preoperatively diagnosed cases had been reported in the English literature as recently as 1959,[1] nine cases have been diagnosed and successfully treated since 1965 at the Indiana University School of Medicine alone.[3]

Attached most commonly to a pedicle which stems from the region of the fossa ovalis, the atrial myxo-

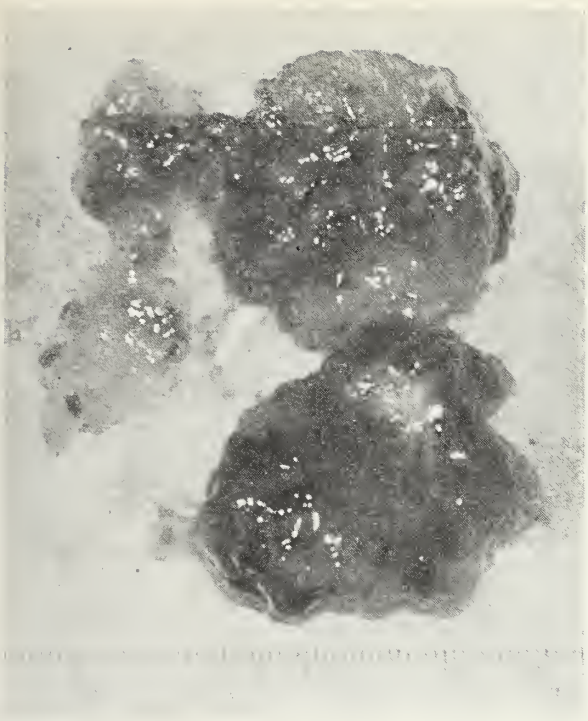


Figure 3
The partially bisected myxoma, ca. 7 cm. in diameter, exhibits the typical gelatinous, translucent appearance. A discrete pedicle was not found in this particular case.

ma is a gelatinous, translucent, golf-ball-sized mass with characteristic histological features which distinguish it as a true neoplasm.[4] Such tumors occur more commonly (3 to 1) in the left than in the right atrium,[1] and their predilection for females is of similar proportions. Atrial myxomata are prone to obstruct A-V valve flow,[5] prolapsing into the valvular orifice in diastole and thereby simulating either mitral or tricuspid stenosis.

The left atrial myxoma, moreover, yields pulmonary hypertension and pulmonary edema, as in the case presented.[6] Unlike mitral stenosis, however, the left atrial myxoma is associated with only mild left atrial enlargement. In similar fashion, the left atrial myxoma is prone to present with a normal sinus rhythm and an unremarkable electrocardiogram.[7] On the other hand, mitral stenosis of a severity sufficient to present with pulmonary edema is more likely to be associated with atrial fibrillation and the electrocardiogram commonly manifests right axis deviation and/or right ventricular hypertrophy.

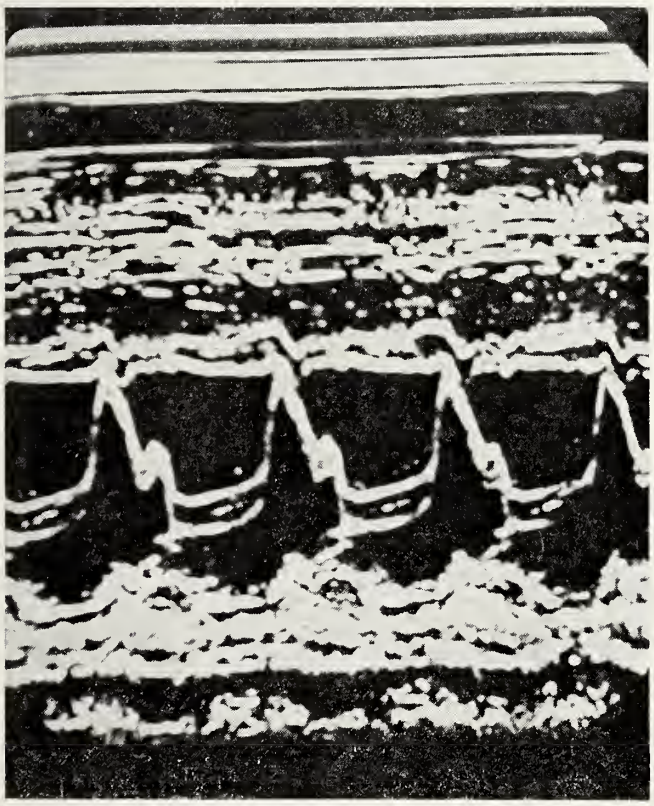


Figure 4
A normal mitral echo is displayed in this postoperative echocardiogram. Following the anterior (upward) motion in early diastole, the anterior leaflets move posteriorly toward a closed position in early diastasis [in contrast to the circumstance in Figure 2 where the anterior leaflet is held anteriorly (upward) by the myxoma]. Postoperatively, also, the area posterior to (beneath) the anterior mitral leaflet is void of echoes.

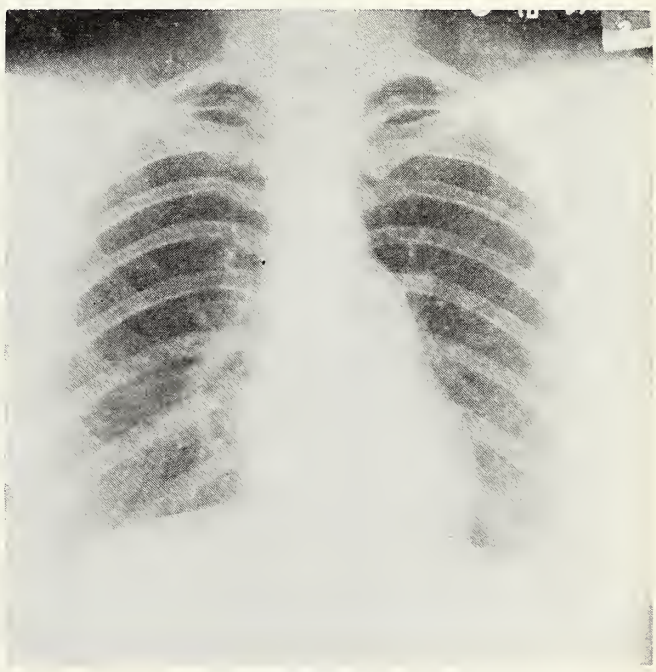


Figure 5
The postoperative chest film is within normal limits, in stark contrast to preoperative film demonstrated in Figure 1.

The auscultatory manifestations of left atrial myxoma are epitomized by this case. The most striking finding is a loud sound, commonly referred to as a "tumor plop," in early diastole and occurring at about the anticipated time of a normal S-3 sound (ca. 0.12 seconds after aortic closure). The latter reflects the passage of the tumor across the mitral valve orifice. As in the case presented, there is frequently heard a subsequent low-pitched diastolic rumbling murmur, occasionally succeeded by a presystolic accentuation. Unlike mitral stenosis, however, S-1 is not appreciably accentuated and an opening snap is not present. Positional alterations in the character of the murmur may also be striking.

Of particularly ominous portent in the course of left atrial myxoma is the likelihood of systemic embolization, occurring in approximately 40% of these friable tumors.[5,8] Whether, in the case presented, the peculiar, painful cutaneous eruptions reflected microemboli has not been ascertained.

The more constitutional manifestations of left atrial myxoma include: fever, anemia, abnormal serum proteins, weight loss, and elevated sedimentation rate.[5,6,9] The present case certainly illustrates the first three of this array. The relation of these systemic disaffections to the cardiac tumor is not fully understood, but there is little question that excision of the tumor is associated with alleviation of these signs and that, therefore, a causal relation presumably exists between the two.

This case report thus illustrates the susceptibility of atrial myxoma to both clinical detection[2,3] and surgical amelioration. And, although it has long been considered an extremely uncommon disorder, the increasing frequency with which myxoma has been encountered in the past decade suggests that this disorder may be more prevalent than had been assumed. In any case, an awareness of the vagaries of this cardiac tumor's clinical manifestations may yield gratifying results.

REFERENCES

1. Pahdi, R.K.; Kelly, H.G.; Lynn, R.B.: Intra-atrial myxoma. *Canad. J. Surg.* 2:414, 1959.
2. Wolfe, S.B., et al: Diagnosis of atrial tumors by ultrasound. *Circulation* 39: 615, 1969.
3. Nasser, W.K., et al: Atrial myxoma 1. Clinical and pathologic features in nine cases. *Am. Heart J.* 83:694, 1972.
4. Pritchard, R.W.: Tumors of the Heart. *Arch. Path.* 51:981, 1951.
5. Goodwin, J.F.: Diagnosis of left atrial myxoma. *Lancet* 1:464, 1963.
6. Goodwin, J.F., et al: Clinical features of left atrial myxoma. *Thorax* 17:91, 1962.
7. Harvey, W.P.: Clinical aspects of cardiac tumors. *Am. J. Cardiol.* 21:328, 1968.
8. Aldridge, H.E., Greenwood, W.F.: Myxoma of the left atrium. *Brit. Heart J.* 22:189, 1960.
9. MacGregor, C.A.; Cullen, R.A.: The syndrome of fever, anemia, and high sedimentation rate with an atrial myxoma. *Brit Med. J.* 2:991, 1959. ◄

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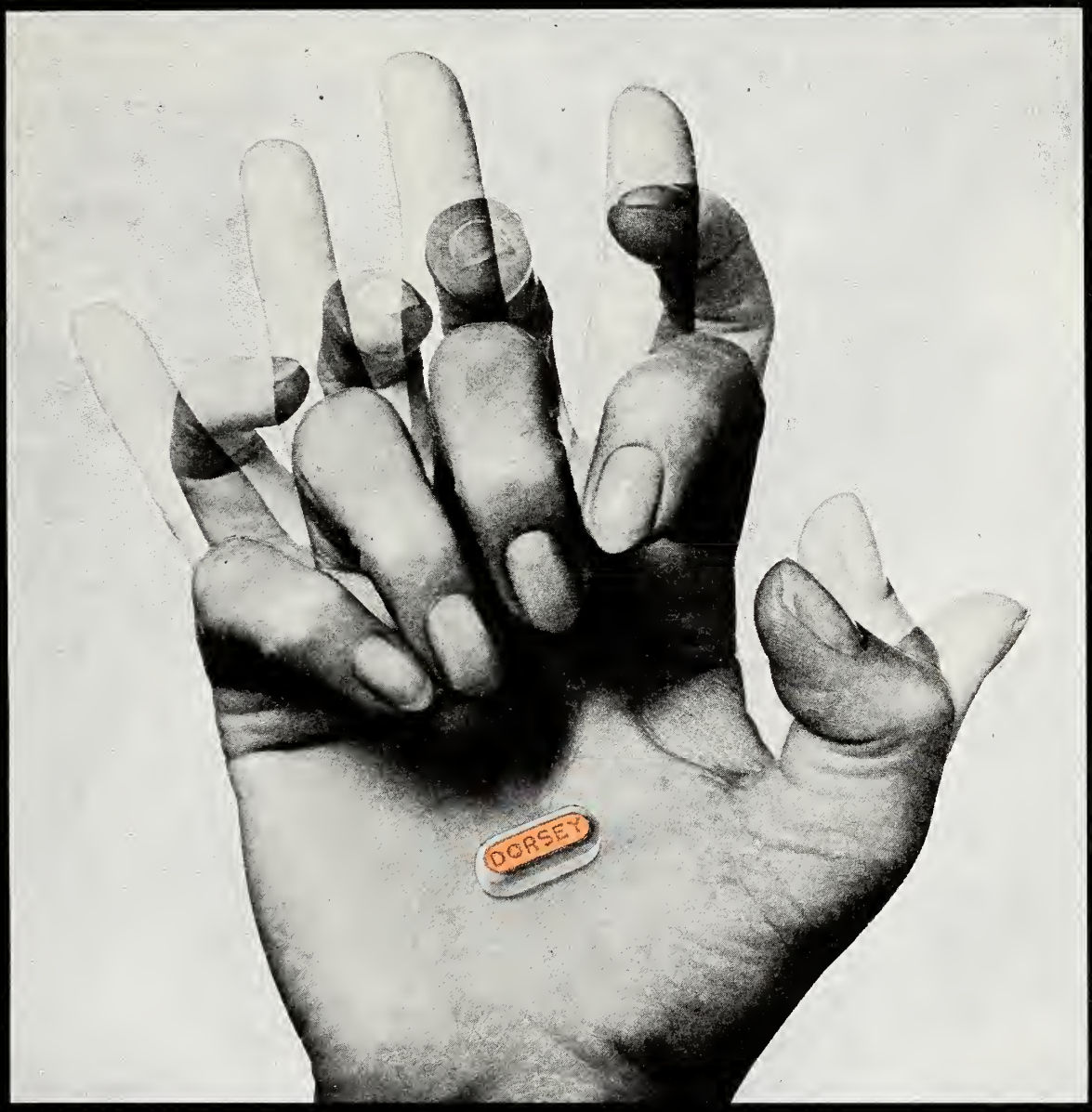
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Registration fee for the day is $35.00, which includes a luncheon. To pre-register, write the IUSM Division of Postgraduate and Continuing Medical Education, 1100 West Michigan, Indianapolis 46202. Preregistration is not a prerequisite. The program will be in Fesler Hall at the Medical Center. Accreditation can be received from the American Academy of Family Physicians and the Physician's Recognition Award.

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HIGH RISK GROUPS— OPPORTUNITY TO IMPROVE CANCER SURVIVAL

by Justin J. Stein, M.D.

(Condensed from *Cancer News,* Vol. 28, No. 1, Spring/Summer 1974, American Cancer Society)

The key to saving three-out-of-six persons who get cancer rather than the present two out-of-six is, ideally, earlier detection of the disease. Present treatment knowledge is adequate for this goal but timely detection and diagnosis lag behind the potential for cure. One important way of successfully improving treatment yield is selective earlier detection—finding persons more likely to have cancer than most others, and providing frequent and inexpensive checkups for them. Short of a universal screening test that would disclose the presence or absence of cancer, identifying high risk groups can be the most effective step in saving more lives today. The ACS is now concentrating on applying existing knowledge to this particular aspect of cancer control through it varied programs for public and professional education.

LUNG CANCER: More is known about the risks of lung cancer than any other cancer site. Cigarette smoking is the cause of at least 80% of carcinoma of the lung. A profile of high risk for this disease is a male, age 55 to 65, who has smoked two or more packs of cigarettes for 20 years and who started smoking before he was 15 years of age.

CANCER OF THE BREAST: The most likely candidates among American women to experience cancer of the breast are: 1) an obese woman, aged 40 to 44; or 2) a woman over age 60 who never had children; or 3) a mother who bore her first child when over 30 years old. They will have a history of benign breast disease, especially bilateral; will be daughters of parents with a familial history of cancer and whose female blood relatives (mother, aunts, sisters) have a history of breast cancer; and will have experienced early menarche and late menopause.

CANCER OF THE UTERUS: A profile of high risk for cancer of the cervix might be a woman aged 50 to 70 years, non-white, immigrant, of low income background, who never had a Pap test or regular checkups, had borne children, had a history of early sexual intercourse and had a frequency of sexual experience with a number of different partners.

For cancer of the endometrium, the highest risk group is in the age of 50 to 65, a woman with late menopause, postmenopausal bleeding, obesity, a tendency toward high blood pressure, and with a history of diabetes.

SAVING MILLIONS: Much remains to be learned, but enough is already known to permit us now to make a greater effort toward saving lives.

We do not need to know why the normal cell is susceptible to malignant transformation to accomplish this goal. What we need to know is *what, when* and *where* and most of these facts already exist or can be obtained through prompt organization. The yield in saving human lives might well run into millions if one asks what share of the 53 million Americans now alive who are destined to have cancer may fall into identifiable high risk groups susceptible to earlier detection and prevention of malignancy.

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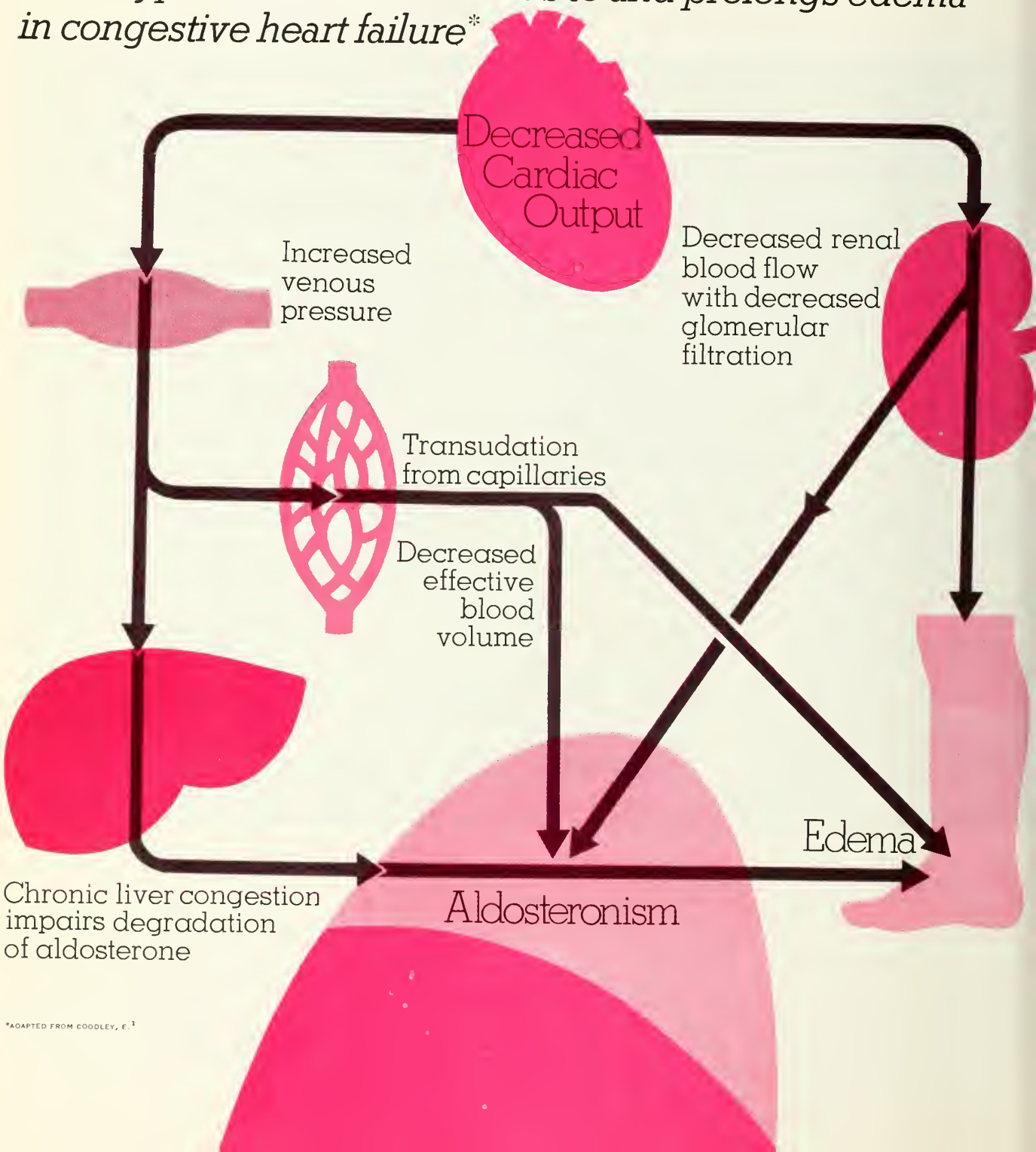
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- Permits daily additive diuretic effect while maintaining potassium balance.

Indications—Essential hypertension; edema or ascites of congestive heart failure, cirrhosis of the liver and the nephrotic syndrome; idiopathic edema. Some patients with malignant effusions may benefit from Aldactone (spironolactone), particularly when given with a thiazide diuretic.

Contraindications—Acute renal insufficiency, rapidly progressing impairment of renal function, anuria and hyperkalemia.

Warnings—Potassium supplementation may cause hyperkalemia and is not indicated unless a glucocorticoid is also given. Discontinue potassium supplementation if hyperkalemia develops. **Usage of any drug in women of childbearing age requires that the potential benefits of the drug be weighed against its possible hazards to the mother and fetus.**

Precautions—Patients should be checked carefully since electrolyte imbalance may occur. Although usually insignificant, hyperkalemia may be serious when renal impairment exists; deaths have occurred. Hyponatremia, manifested by dryness of the mouth, thirst, lethargy and drowsiness, together with a low serum sodium may be caused or aggravated, especially when Aldactone is combined with other diuretics. Elevation of BUN may occur, especially when pretreatment hyperazotemia exists. Mild acidosis may occur. Reduce the dosage of other antihypertensive drugs, particularly the ganglionic blocking agents, by at least 50 percent when adding Aldactone since it may potentiate their action.

Adverse Reactions—Drowsiness, lethargy, headache, diarrhea and other gastrointestinal symptoms, maculopapular or erythematous cutaneous eruptions, urticaria, mental confusion, drug fever, ataxia, gynecomastia, inability to achieve or maintain erection, mild androgenic effects, including hirsutism, irregular menses and deepening voice. Adverse reactions are infrequent and usually reversible.

Dosage and Administration—For **essential hypertension** in **adults** the daily dosage is 50 to 100 mg. in divided doses. Aldactone may be combined with a thiazide diuretic if necessary. Continue treatment for two weeks or longer since an adequate response may not occur sooner. Adjust subsequent dosage according to response of patient.

For edema, ascites or **effusions** in **adults** initial daily dosage is 100 mg. in divided doses. Continue medication for at least five days to determine diuretic response; add a thiazide or organic mercurial if adequate diuretic response has not occurred. Aldactone dosage should not be changed when other therapy is added. A daily dosage of Aldactone considerably greater than 75 mg. may be given if necessary.

A glucocorticoid, such as 15 to 20 mg. of prednisone daily, may be desirable for patients with extremely resistant edema which does not respond adequately to Aldactone and a conventional diuretic. Observe the usual precautions applicable to glucocorticoid therapy; supplemental potassium will usually be necessary. Such patients frequently have an associated hyponatremia—restriction of fluid intake to 1 liter per day or administration of mannitol or urea may be necessary (these measures are contraindicated in patients with uremia or severely impaired renal function). Mannitol is contraindicated in patients with congestive heart failure, and urea is contraindicated with a history or signs of hepatic coma unless the patient is receiving antibiotics orally to "sterilize" the gastrointestinal tract.

Glucocorticoids should probably be given first to patients with nephrosis since Aldactone, although useful for diuresis, will not directly affect the basic pathologic process.

For **children** the daily dosage should provide 1.5 mg. of Aldactone per pound of body weight.

References: 1. Coodley, E.: Consultant 12:106-107, 109, 111, 113, 115 (July) 1972. **2.** Thorn, G. W., and Lauler, D. P.: Am. J. Med. 53:673-684 (Nov.) 1972.

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The Role of the Detail Man

Opinion & Dialogue

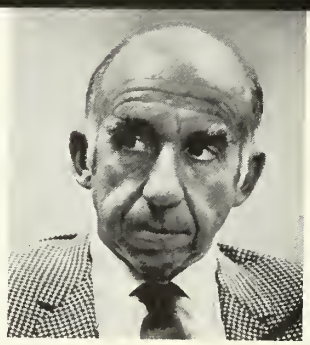


Dr. Willard Gobbell
Family Physician
Encino, California

"I may be prejudiced, but I ar very much in favor of the detail me I meet. Most of them are knowledg able about the drugs they promote and can be a great help in acquain ing me with new medication."

Family Physician's Perception

I think that most general practitioners in this area feel as I do about the detail man. Over the years I have gotten to know most of the men who visit me regularly and they in turn have become aware of my particular interests and the nature of my practice. They, therefore, limit their discussion as much as possible to the areas of interest to me. Since I usually see the same representative again in future visits, it is in his best interest to supply me with the most honest, factual, as well as up-to-date information about his products.



Dr. Jeremiah Stamler
Chairman
Department of Community Health and Preventive Medicine, and Dingman Professor of Cardiology
Northwestern University Medical School

"In the total picture of dealing with health problems in this countr there is a potential for detail men to play a meaningful role."

The Positive Influence

My contact with representatives and salesmen of the pharmaceutical industry is the type of contact that people in a medical center research people, and academic people have and that's in all likeliho on a somewhat different level from that of the practicing physician.

Let me touch on how I personally perceive the role of the sales representative. These men reach large numbers of health professionals. Thus they could be—and at times actually are—disseminators of useful information. They could consistently serve a real educational function in their ability to discuss their products.

At present they do distribute printed material, brochures and pamphlets—some of it scientifically sound and therefore truly useful—as well as some excellent films produced by the pharmaceutical industry. When they function in this

s He a Source of Information?

Yes, with certain reservations. he average sales representative as a great fund of information bout the drug products he is ponsible for. He is usually able to nswer most questions fully and ntelligently. He can also supply eprints of articles that contain a reat deal of information. Here, oo, I exercise some caution. I usu-lly accept most of the statements nd opinions that I find in the apers and studies which come rom the larger teaching facilities. goes without saying that a physi-ian should also rely on other ources for his information on harmacology.

raining of Sales Representatives

Ideally, a candidate for the osition as a sales representative f a pharmaceutical company hould be a graduate pharmacist vho has a questioning mind. I don't hink this is possible in every case, nd so it becomes the responsibility of the pharmaceutical company to train these individuals comprehensively. It is of very great importance that the detail man's knowledge of the product he represents be constantly reviewed as well as updated. This phase of the sales representative's education should be a major responsibility of the medical department of the pharmaceutical company.

I am certain that most of these companies take special care to give their detail men a great deal of information about the products they produce—information about indications, contraindications, side effects and precautions. Yet, although most of the detail men are well informed, some, unfortunately, are not. It might be helpful if sales representatives were reassessed every few years to determine whether or not they are able to fulfill their important function. Incidentally, I feel the same way about periodic assessments of everyone in the health care field, whether they be general practitioners, surgeons or salesmen.

Value of Sampling

I personally am in favor of limited sampling. I do not use sampling in order to perform clinical testing of a drug. I feel that drug testing should rightly be left to the pharmacology researcher and to the large teaching institutions where such testing can be done in a controlled environment.

I do not use samples as a "starter dose" for my patients. I do, however, find samples of drugs to be of value in that they permit me to see what the particular medication looks like. I get to see the various forms of the particular medication at first hand, and if it is in a liquid form I take the time to taste it. In that way I am able to give my patients more complete information about the particular medications that I prescribe for them.

apacity they are indeed useful; articularly in the fact that they isseminate broadly based educa-ional material and serve not just s "pushers" of their drugs.

he Other Side of the Coin

Obviously, the pharmaceuti-al companies are not producing all his material as a labor of love—ney are in the business of selling roducts for profit. In this regard he ambitious and improperly moti-ated sales representative can xert a negative influence on the racticing physician, both by pre-enting a one-sided picture of his roduct, and by encouraging the ractitioner to depend too heavily n drugs for his total therapy. In hese ways, the salesman has often istorted objective reality and ndermined his potential role as an ducator.

The Industry Responsibility

Since the detail man must be n information resource as well as representative of his particular harmaceutical company, he hould be carefully selected and thoroughly trained. That training, perforce, must be an ongoing one. There must be a continuing battle within and with the pharmaceutical industry for high quality not only in the selection and training of its sales representatives, but also in the development of all of its promotional and educational material.

The industry must be ready to accept constructive as well as corrective criticism from experts in the field and consumer spokesmen, and be willing to accept independent peer review. The better educated and prepared the salesman is, the more medically accurate his materials, the better off the pharmaceutical industry, health professionals and the public—*i.e.*, the patients—will be.

Physician Responsibility

The practicing physician is in constant need of up-dated information on therapeutics, including drugs. He should and does make use of drug information and answers to specific questions supplied by the pharmaceutical representative. However, that information must not be his main source of continuing education. The practitioner must keep up with what is current by making use of scientific journals, refresher courses, and information received at scientific meetings.

The practicing physician not only has the right, but has the responsibility to demand that the pharmaceutical company and its representatives supply a high level of valid and useful information. I feel certain that if such a high level is demanded by the physician as well as the public, this demand will be met by an alert and concerned pharmaceutical industry.

From my experience, my impression is that sectors of the pharmaceutical industry are indeed ethical. I challenge the industry as a whole to live up to that word in its finest sense.

Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005



Satiety Sensations and Control of Body Weight

MARK I. HEWITT, M.D.*
Saint Paul, Minn.

THE total number of overweight persons in the United States has been estimated to be from 20 to 60 million. Concern over weight control, or often the lack of it, has become a widespread preoccupation. Customarily, groups under study when classified by body weight fall into three cohorts: underweight, satisfactory weight and overweight. However, the arbitrary assignation of patients to these groups does not clarify or elicit how individual members of the group view the magnitude of the weight-control *problem.*

It seemed reasonable to explore how persons within a population sample may look at the matter of weight control. Some, for example, may have no weight-control problem; others may believe they themselves can control what problem they have; and still others may feel unable to control their weight by any measure tried. If such weight-problem groups could be delineated, they should lend themselves to comparative study in respect to satiety sensations and to susceptibility and sensitivity to "external" and "internal" cues related to satiety.

Method

Approximately 1,000 questionnaires,[1] modified slightly from that used originally by Mayer et al.,[2] were distributed randomly over a period of about 15 months among medical products and pharmaceutical professional sales representatives and their wives, located throughout the United States, and to administrative office personnel, to members of two groups interested in weight reduction, and to undergraduate nurses in the Saint Paul, Minn., area. Distribution of the questionnaire was intentionally made by third parties, e.g., national sales managers, nonmedical or paramedical personnel, and a director of nursing education.

In brief, this questionnaire was designed to explore in depth hunger and satiety under various circumstances, to dwell in detail upon certain meal-related items as food preoccupation, meal-skipping, beverage ingestion and snacking, and to relate these events to meals. Each questionnaire was accompanied by full instructions for its completion as well as an explanation of its purpose—to obtain as much information as possible about hunger and satiety sensations. The questionnaire, highly structured and consisting of 100 multiple-choice questions, was to be filled out without interruption *after* an evening meal. About 30 to 45 minutes were required for its completion. The one modification pertinent to this report consisted of having each respondent choose one of the three following weight-problem categories: 1) "I've always been able to eat anything I want and have no weight problem"; 2) "What weight problem I have I can control myself by watching what I eat without having to go on a special diet or seeing my doctor"; or 3) "I am unable *by myself* to control my weight and have tried diets with or without my doctor's supervision. My weight has tended to go up unless I diet and I've had several ups and downs." Respondents were also asked to classify themselves as being underweight, overweight, or of satisfactory weight.

Among the 100 questions were several that attempted to pinpoint certain eating habits (e.g., plate-clearing, overeating and snacking) and satiety sensations (e.g., fullness at meal's end, reasons for stopping eating, amount of willpower needed to stop eating). Indirectly by means of these questions the relative contribution of "internal" and "external" cues to satiety sensations among these respondents was sought.

Data were tabulated and contingency table analyses were performed through the use of a computer. Statistically significant differences were evaluated at a risk level of $p<.05$ using the Chi-Square distribution.

Results

Of all questionnaires distributed, a total of 747 respondents, 302 males (40%) and 445 females (60%), returned a completed questionnaire. All respondents self-classified their current weight as either underweight (UWT), satisfactory (SAT) or overweight (OWT). Of these, 719 (96%), 286 males (40%) and 433 females (60%), self-classified their weight-control problem as either no weight problem (NWP), self-controlled weight problem (SC), or no weight control (NWC). The resulting categories are shown in Table 1 and certain demographic data in Table 2. It can be seen that among these respondents the number of males and females in either the underweight (UWT) or no weight problem (NWP) category is about the same. However, in the satisfactory weight (SAT) or self-controlled (SC) weight problem category, the number of females showed a relative increase over males. This trend continued into the overweight (OWT) or no weight control (NWC) cate-

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TABLE 1. WEIGHT CATEGORIES OF RESPONDENTS

Self-Classified Weight

Sex	U Wt.	%	Sat Wt	%	O Wt.	%
Male	22	3	100	13	180	24
Female	30	4	132	18	283	38

Self-Classified Weight Problem

Sex	NWP	%	SC	%	NWC	%
Male	77	10	149	21	60	8
Female	86	12	197	28	150	21

TABLE 2. DEMOGRAPHIC DATA

ITEM		Male (N=302)		Female (N=445)	
		Total	Percent	Total	Percent
College Education		264	87	261	59
Highschool Education		38	11	168	38
Ages					
N	Group				
243	18-25	28	12	215	88
232	26-35	128	55	104	45
161	36-45	91	57	70	43
82	46-55	42	51	40	49
26	56-65	12	46	14	54

gory where in the former there were one-third more females than males (283 *vs* 180) and in the latter, two and one-half times more females than males (150 *vs* 60).

Sex more than age determined distribution into weight-problem groups. However, younger females fell significantly more often into NWP and SC groups, and the older into NWC group.

A brief explanation of the data in Figures 1-7 is warranted. The questionnaire was devised to enable one to determine whether there were significant differences between the responses of NWP, SC, and NWC to the questions relating to satiety. Of particular interest was the distribution of the responses made by each weight-problem group and whether significant differences in the distribution of responses existed between these groups. In all data presented in Figures 1 through 7 inclusive, the distribution of responses was significantly different ($p<.05$) between two or more weight-problem groups.

The so-called "internal" cues for satiety—the satiety sensations—appear to be represented by sensations such as "fullness in the stomach," "bloating," epigastric distention, and abdominal or epigastric uncom-

FIGURE 1. FULLNESS AT END OF MAJOR MEAL

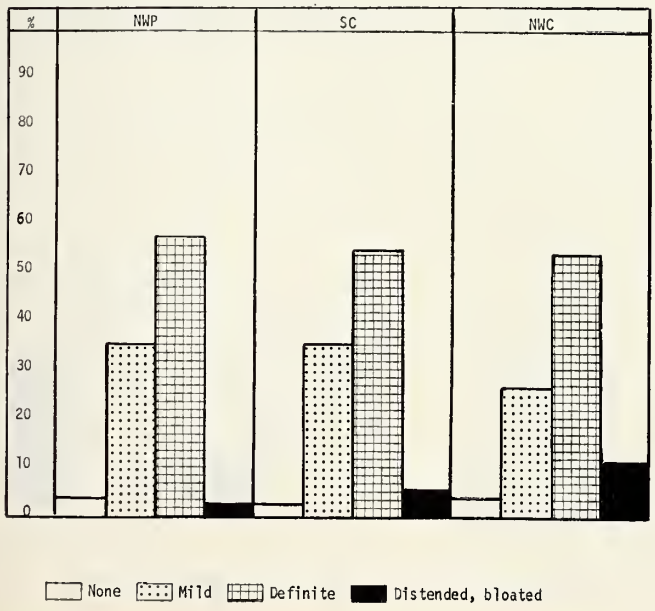


FIGURE 2. REASONS EATING STOPPED AT END OF MAJOR MEAL

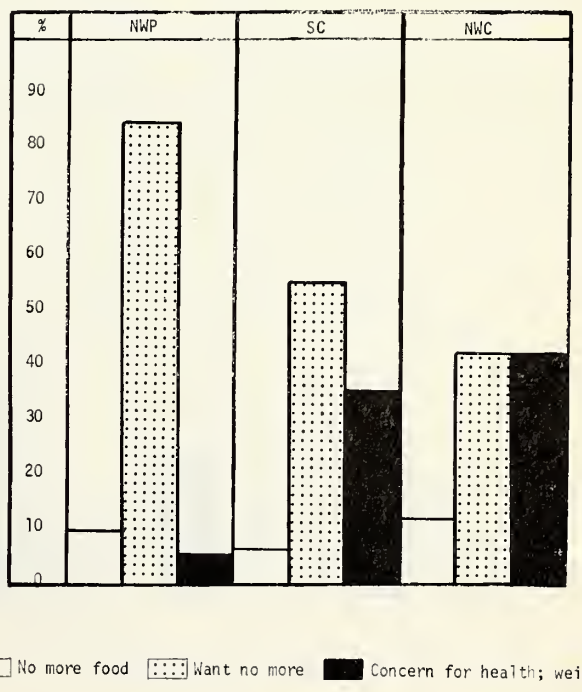


FIGURE 3. WILLPOWER NEEDED TO STOP EATING AT END OF MAJOR MEAL

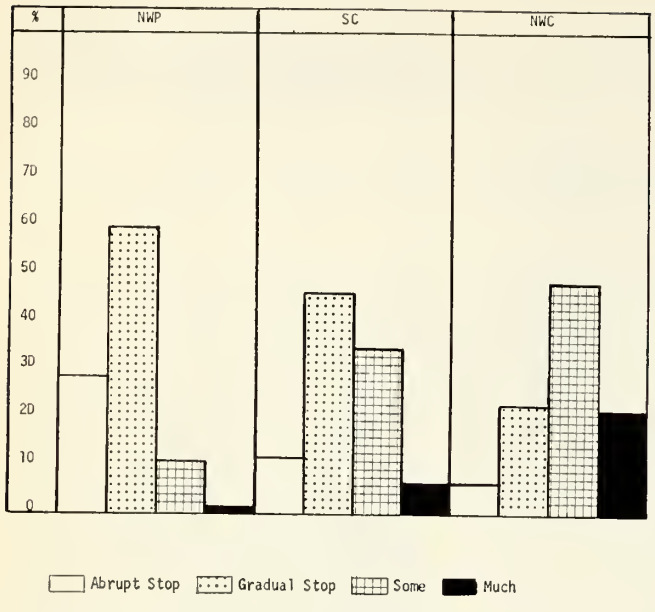
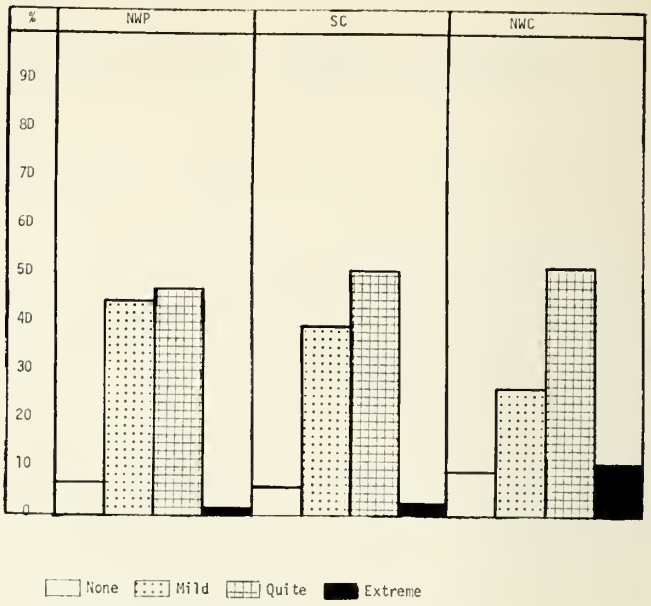


FIGURE 4. DISCOMFORT IF EATING STOPPED AFTER FEW BITES



fortableness after meals. While the majority of all respondents admitted to definite fullness after a major meal, the distribution of responses showed NWC to be apparently less sensitive to the internal cue of fullness than NWP and SC (Figure 1), in that a larger number proceeded to distention and bloating. In part, the degree of awareness to internal satiety cues may have been reflected in the reasons given for stopping eating at the end of a major meal (Figure 2). The majority of NWP stopped eating because they wanted no more food, whereas in NWC most responses were equally divided between concern with health and weight and wanting no more food, SC occupying a position in between NWP and NWC. Similarly, when the amount of willpower needed to stop eating was assessed, the significant differences in distribution of responses between weight-problem groups was obvious (Figure 3). It appeared that the greater the weight-control problem, the greater the amount of willpower needed to stop eating.

These data seemed to lend support to the belief that the greater the weight problem, the less the sensitivity to "internal" cues for satiety. However, some consideration was given to the influence an overriding susceptibility to "external" cues may have. One "external" cue bearing a relation to satiety is the presence

FIGURE 5. PLATE CLEARING WITH NO DESIRE TO EAT MORE

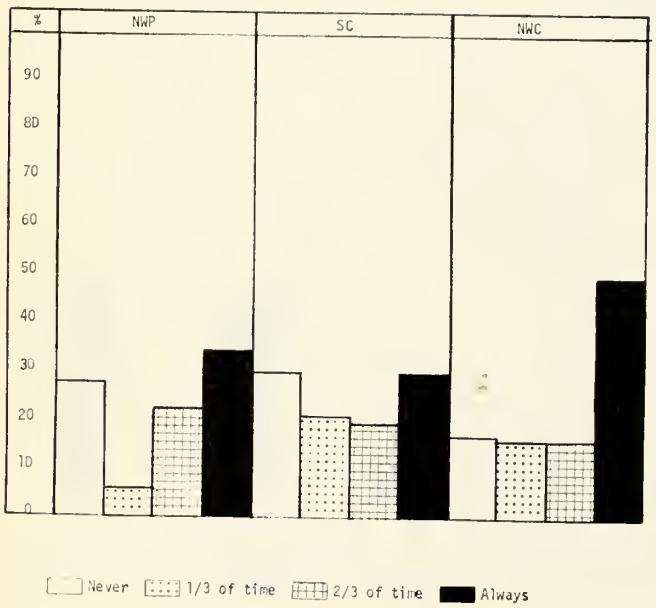
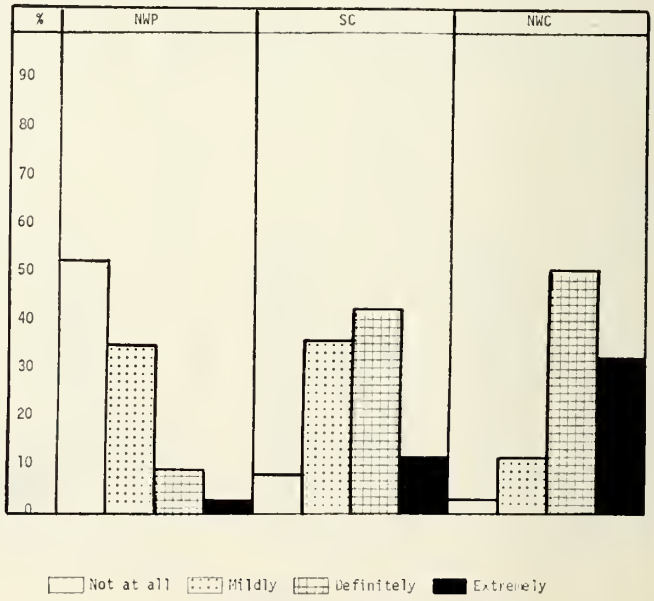


FIGURE 6. DEGREE OF CONCERN WITH OVEREATING

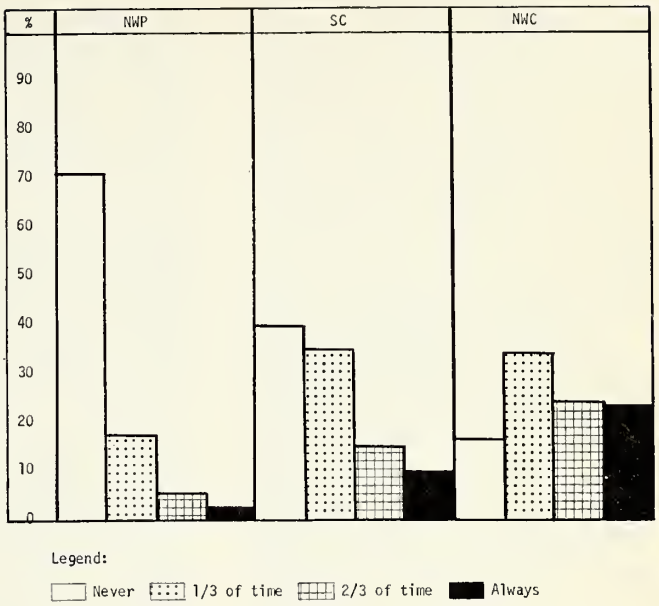


of food, a major factor contributing to the magnitude of the weight-control problem in certain of these respondents.

Specific questions in the questionnaire had been designed to bring out the role played by the presence of food. For example, those with the greater weight problem should have found it more difficult to stop eating after a few bites, at least in part because of the "external" cueing effect of visualizing a plate of food. Figure 4 shows the effect the degree of weight problem had on stopping eating after a few bites—the greater the weight problem, the more discomfort was felt if eating stopped after a few bites. More than 80% of all respondents always or nearly always cleared their plates, there being no significant differences in the distribution of responses to this question between NWP, SC, or NWC. However, when respondents were asked if they wanted no more to eat, how often they still cleared their plate, significant differences in responses between weight-problem groups appeared (Figure 5). Whereas the distribution of responses for NWP and SC were similar, those of NWC skewed toward the greater frequency of plate clearing under this circumstance.

However, the mere presence of food manifested by a concern for overeating indirectly appeared also to exert its influence (Figure 6). The distribution of responses was significantly different between NWP, SC, and NWC, the last-named group showing a much higher degree of concern than NWP, SC occupying a point similar to expected normal distribution. As a source of overeating, the more snacking and nibbling contributed to overeating, the greater the weight-control problem (Figure 7). Again, distribution of responses between weight-problem groups was significant.

FIGURE 7. OVEREATING FROM SNACKING AND NIBBLING



Discussion

Mayer and co-workers[2-5] have pioneered efforts to describe hunger and satiety sensations in man. In fact, Mayer[6] proposed a glucostatic mechanism as a component of satiety. At the same time, he pointed out that this mechanism may exist in addition to other factors, such as metering of food intake by mouth or pharynx, taste, emotions, or habits, any of which may influence food intake at any given time.

Investigative explorations concerning the regulation of food intake in man, irrespective of his body weight, have resulted in some interesting observations. Stunkard,[7] for example, pointed out that it is the exceptional obese person who is a voracious eater or who desires food in the way an addict craves drugs or an alcoholic, alcohol. The obese in a hospital environment rarely overeat; yet, they will eat more than will those of normal weight if food is readily accessible, an observation confirmed by Schacter.[8] If access to food is impeded or the food is unpalatable, the obese eat less than do those normal in weight.

Nisbett[9] has observed that the more an individual weighs, the less he responds to internal, physiologic cues and the more responsive he is to external cues, a belief supported also by Schacter.[10] So much do the obese appear to be governed by external cues leading to increased food intake that Sheldon[11] has been led to comment that gastric distention and motility are probably minor factors affecting food intake in man. Schacter's[8] brilliant experiments showed, in part, that the obese ate just as much with the stomach empty as full. However, Wooley,[12] under the conditions of his experiment, found the food intake of the obese no different from that of normals, although he concluded that the self-rated hunger of the obese was appetitive and of the nonobese, physiologic.

Determinants of satiety in the obese are apparently dependent on external cues although Stellar and Jordan[13] have stated that perception of satiety may be the absence of signals for hunger as well as a full stomach or a "satisfied" oral cavity. In this respect, McClure and Brusch[14] have reported that 80% of their obese patients were oral types who, though not hungry, wanted to be orally active and resorted to snacking excessively.

Another "external" cue may be the increased responsiveness to external stimuli as noted by Schacter[8] who considered the obese not only more emotional than the nonobese but also more efficient processors of stimuli or information and

more easily distracted than normals. This may support the observation of Meyer and Pudel[15] that a hyperphagic reaction to stress may be one pathogenetic factor in obesity and that of the author[16] who observed among those with a major weight-control problem a high incidence of negative mood that abruptly reversed to a positive mood upon eating.

Although it is not possible to be certain that the population sampled in this study is representative of the general population, it is tempting to extrapolate from these results to the general population. Data derived from answers to this questionnaire appeared to support in some respects certain data reported by others. For example, Nisbett,[9] who provided sandwiches to underweight, normal weight or overweight males found overweight subjects offered three sandwiches ate more than underweight or normal weight persons; however, when offered only one sandwich, the overweight ate no more than the normal or underweight persons, suggesting that the obese habitually will eat everything served in a typical meal. Among these same subjects, the greater the weight, the more often the plate was cleared. Frequency of plate clearing by respondents to this questionnaire study showed no significant differences between weight-problem groups except as shown in Figure 5.

Whereas McClure and Brusch[14] observed males and females to snack with equal frequency, female respondents in this study snacked significantly more frequently than males.

Conclusions

When this study was contemplated, it was conjectured that within the general population there may be a segment able to control their weight within reasonable limits solely through their own efforts and that a questionnaire might be a useful tool to determine how this group differed from those unable to manage their weight. As seen in Table 1, it appears that many who believed they could control their weight themselves (SC), when asked to appraise their own weight status, also believed themselves overweight (OWT). Thus, the "satisfactory weight" (Sat Wt) or SC subgroups may loom as a constant reservoir for those eventually becoming OWT and NWC subgroups.

One reasonable conclusion based on this study is that the effect of "external" cues in promoting the overweight problem is most pronounced in those having no weight control (NWC) but is present also to a definite though lesser degree in those self-controlling (SC) their weight. This is reinforced by the comparative responses to "external" cues made by SC and NWC respondents and those having no weight problem (NWP).

Preventive medicine may have the opportunity of putting one of its best feet forward by attempting to slow the apparently increasing numbers of obese persons. Each physician should concentrate his efforts not only on those patients whose prospects for excess weight are imminent but also on those whose weight problem is relatively modest. These efforts should include the technics used in modifying eating behavior, for these focus attention on the effects of external cues, apparently so persuasive in the obese. Overall management, in addition, should include appropriate dietary and nutritional counseling and the occasional, judicious and selective use of appropriate medication.

ACKNOWLEDGMENTS

The author wishes to acknowledge his sincere appreciation for the excellent guidance and statistical review provided by Mr. Kenneth D. Kotnour and for the efficient secretarial assistance of Ms. Bonnie Olinger.

REFERENCES

1. Hewitt, M.I.: Respondents' self-appraisal of weight control. A preliminary report. Presented at the annual meeting, American Society of Bariatric Physicians, Las Vegas, Oct. 5, 1972.
2. Mayer, J.; Monello, L.F.; Seltzer, C.C.: Hunger and satiety sensations in man. *Postgrad. Med.* 37:A97, 1965.
3. Monello, L.F.; Seltzer, C.C.; and Mayer, J.: Hunger and satiety sensations in men, women, boys and girls: A preliminary report. *Ann. N.Y. Acad. Sci.* 131:593, 1965.
4. Monello, L.F.; Mayer, J.: Hunger and satiety sensations in men, women, boys, and girls. *Am. J. Clin. Nutr.* 20:253, 1967.
5. Mayer, J.; Thomas, D.W.: Regulation of food intake and obesity. *Science* 156:328, 1967.
6. Mayer, J.: The ventromedial glucostatic mechanism as a component of satiety. *Postgrad. Med.* 38:A101, 1965.
7. Stunkard, A.J.: Environment and obesity: Recent advances in our understanding of regulation of food intake in man. *Fed. Proc.* 27:1369, 1968.
8. Schacter, S.: Some extraordinary facts about obese humans and rats. *Am. Psychol.* 26:129, 1971.
9. Nisbett, R.E.: Determinants of food intake in obesity. *Science* 159:1254, 1968.
10. Schacter, S.: Obesity and eating. *Science* 161:751, 1968.
11. Sheldon, J.: Obesity: Some current views regarding its aetiology. *Postgrad. Med.* 46:613, 1970.
12. Wooley, O.W.: Long-term food regulation in the obese and nonobese. *Psychosomat. Med.* 33:436, 1971.
13. Stellar, E., Jordan, H.: Perception of satiety. *Res. Publ. Assoc. Res. Nerv. Ment. Dis.* 48:298, 1970.
14. McClure, C.W., Brusch, C.A.: Treatment of oral syndrome obesity with non-traditional appetite control plan. *J. Ann. Med. Wom. Assoc.* 28:239, 1973.
15. Meyer, J.E., Pudel, V.: Experimental studies on food-intake in obese and normal weight subjects. *J. Psychosomat. Res.* 16:305, 1972.
16. Hewitt, M.I.: Negative mood, hunger and weight classification. *Obesity/Bariatric Med.* 3:24, 1974. ◄

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On Listening

GORDON T. BROWN, M.D.
Indianapolis

"I know that you believe you understand what you thought I said, but I am not sure that you realize that what you heard is not what I meant," the Marion County Medical Society *Bulletin* recently quoted.

As I sit down to write, I have just returned from an early morning walk in the country. It is a Sunday in August and it started out sunny and bright.

My path took me past the school, the tennis courts, the football field —and in reverie I heard the thwack of the tennis balls, the roar of the crowd, the happy sounds of children at play.

But as I walk on today, it is a time of solitude—of reflection—amidst the sound of the wind, the rustle of the trees, the lowing of the cattle, the birds' song—sounds often unheard and unheeded in the busyness of life and of work.

I had thought to ride a bike—but preferred to walk—less mechanical, less speed—and more time for reflection. Where I am—where I've been—and where I am going. A time to listen to myself—away from the cacophony of the world.

I think of my work—and I think of the changes impinging on it. The heritage of the past, the art of medicine—as it was taught to me and as I have tried to practice it. Now I see it being taught by those who rarely treat persons—just diseases—to students who will identify with them—and may never treat patients as persons—but as the case in 1002—the gall bladder—the depressed—the schizo.

I see patients who have been subjected to a plethora of studies, examinations and tests—but to no one who has taken the time and the interest to sit and listen to the hurting person within—the personality that overlies all the laboratory and x-ray and psychological reports. These may have added to the doctors' information or represented good "defensive medicine." But did they help the patient? And is that not our calling?

I see patients who have been hospitalized unnecessarily, at great emotional and financial expense to them, their families, their insurance companies—and subjected to a variety of procedures—because no one went to the effort to sense their feelings and plumb the real problems within—problems that did not lie in blood chemistries or brain scans. Such may be of value in ascertaining the function of particular organs or systems and sometimes are necessary. But what do they tell about the heart of a child, the growing pains of an adolescent, the wrenched soul of an adult?

Shakespeare said, "Knock there; and ask your heart what it doth know." Or are we so clinical that a heart is just a heart? Reich said, "Men reveal themselves when they talk freely about themselves," and he also spoke of maintaining a "free floating attention."

The essence of what I want to say was well said long ago by Hawthorne.

> So the man of skill, the kind and friendly physician, strove to go deep into his patient's bosom, delving among his principles, prying into his recollections, and probing everything with a cautious touch, like a treasure seeker in a dark cavern. Few secrets can escape an investigator who has opportunity and license to undertake such a quest and skill to follow it up. The man burdened with a secret should especially avoid the intimacy of his physician. If the latter possess native sagacity and a nameless something more, let us call it intuition; if he show no intrusive egotism nor disagreeably prominent characteristics of his own; if he has the power which must be born with him to bring his mind into such affinity with his patients, that this last shall unawares have spoken what he imagined himself only to have thought; if such revelations be received without tumult and acknowledged not so often by an uttered sympathy as by silence, an inarticulate breath, and here and there a word to indicate that all is understood; if to these qualifications of a confidant be joined the advantages afforded by his recognized character as a physician—then at some inevitable moment will the soul of the sufferer be dissolved, and flow forth in a dark but transparent stream, bringing all its mysteries into the daylight.

But Shakespeare asks the easy way many request today.

> Canst thou not minister to a mind diseas'd;
> Pluck from the memory a rooted sorrow;
> Raze out the written troubles of the brain;
> And with some sweet oblivious antidote
> Cleanse the stuff'd bosom of that perilous stuff
> Which weighs upon the heart?

In the opinion of some of us still, most emotional problems have their origins in significant interpersonal relationships—and therein will lie their healing—in a relationship with someone who cares and who will listen. Not in a bottle of pills—or a shock box—or a computer. But in the I-Thou relationship of which Buber and Sullivan speak, wherein the dignity, worth, meaning and full realization of a person's potential as a person may be actualized.

If there are none so blind as those who will not see; there are none so deaf as those who will not hear.

Many patients recall their past medical and surgical encounters with memories of fears unstilled by an understanding physician. Others have said, "This is one place I can relax and be me." "My wife asked me what you said—I thought—and

said, 'He said nothing—just listened, but it helped.' " "I do not want your advice; I just want you to listen and understand." "It helps to hear how I really feel." "Thank you for understanding and not just giving me pills." "Nobody's ever listened to me."

Another patient brought in a sheet he had printed of some extrapolations from our sessions to use in his business.

Words used to communicate. Objective—to communicate—to relate one to the other—to gain an interpersonal relationship by provoking thought processes on the part of both parties.

1) What do *you* want to do?
   (Listen)
2) Who expects you to do what you are doing and what do *you* think you should do?
   (Listen)
3) Does this create a conflict for you?
   (Listen)
4) Elaborate.
   (Listen)
5) How do *you* feel about that?
   (Listen)
6) By whose standard?
   (Listen)
7) Is this *your* decision?
   (Listen)

I stepped over a lucky penny on my path and almost couldn't find it when I turned back to pick it up. I thought how many sensitive fortuitous insights are overlooked in the pursuit of a complete history or a blood level or the proper dosage —and the psychopharmacological battle won—but the war—and the patient lost. If we tune out the extraneous chatter and hear the voice of the heart of the man, we may, like Hawthorne, be rewarded and find the lucky penny.

It has been said that in psychiatry the doctor's primary therapeutic tool is his own caring personality. But what if he doesn't have one or take the time to use it. The patient wants objective, understanding acceptance —the sine qua non of any successful insight therapy. But it is not possible to understand unless you have listened.

Some therapists are learned and technically impeccable—capable of going through all the proper motions without hearing and without understanding. Their improverishment of empathy leaves them therapeutically sterile. Others can listen and understand and help immeasurably. Many years ago an older, wiser mentor counseled me as a resident faced with a frustrating recalcitrant patient: "There's more to psychiatry than pills and electricity."

In *The Divided Self,* Laing makes the statement that the sick person ceases to be sick when he meets someone by whom he feels he is understood. When this happens, most of the bizarreness taken as the signs of the disease simply evaporates.

Meeting you makes me feel like a traveler who has been lost in a land where no one speaks his language. Worst of all the traveler doesn't even know where he should be going. He feels completely lost and helpless and alone. Then suddenly, he meets a stranger who can speak English. Even if the stranger doesn't know, it feels so much better to be able to share the problem with someone, to have him understand how badly you feel. If you are not alone, you don't feel hopeless anymore. Somehow, it gives you life and a willingness to fight again. Being crazy is like one of those nightmares where you try to call for help and no sound comes out. Or if you can call, no one hears or understands. You can't wake up from the nightmare unless someone does hear you and helps you to wake up.

The main agent in uniting the patient and allowing the pieces to come together and cohere is the physician's care—a care that recognizes the patient's total being and accepts it with no strings attached.

In his recent book, *The Night Country,* Loren Eiseley stated:

If you cannot bear the silence and the darkness, do not go there. If you dislike black night and yawning chasms, never make them your profession.

As I was returning home from my country walk I noticed it had become cooler, with quickening wind and lowering sky—and a slight chill swept through me. Was this a portent of an early autumn too soon upon us?

And I wondered—is it the autumn of the practice and the art of medicine and psychiatry as I have known it? It remains to be seen—but it may be. How is empathy graded on a PSRO scale? Or understanding—or compassion? Voices from the past and voices from the future. If medicine becomes 1984—the art—and the heart—will be different.

The witch doctors, shamans and high priests gave way to the physician. Now the physician appears to be abdicating—and witness the accelerating return to the latter day gurus and seers.

A verse from an unknown pen bespeaks the lacunae in the healing arts.

Please Hear What I Am Not Saying.

Don't be fooled by me, don't be fooled by the face I wear, for I wear a mask. I wear a thousand masks . . . masks that I am afraid to take off and none of them are me. Pretending is an art that is second nature with me, but don't be fooled, for God's sake don't be fooled. I give you the impression that I am secure. That all is sunny and unruffled with me within as without . . . That confidence is my name and coolness is my game. That the waters are calm, I am in command and I need no one. But don't believe me. Please don't. My surface may seem smooth, but my surface is my mask, my ever-varying and ever-concealing mask. Beneath dwells the real me, in confusion, in fear, in aloneness. But I hide this. I don't want anyone to know it. I panic at the thought of my weakness and I fear being exposed. That is why I frantically create a mask to hide behind—a nonchalant, sophisticated facade to help me pretend—to shield from the glance that knows. But such a glance is precisely my salvation, my only salvation, I know it. That is, if that glance is followed by acceptance . . . if it is followed by love. It is the only thing that can liberate me from myself. From my own self-built prison walls . . . from the barriers that I so painstakingly erect. It is the only thing that will assure me of what I can't assure myself . . . that I'm really worth something. But I don't tell you this. I don't dare. I'm afraid to. I'm afraid your glance will not be followed by love and acceptance. It's the only thing that can liberate me. I'm afraid that you will think less of me, that you will laugh and your laugh would kill me. I'm afraid that deep down I'm nothing. That I'm just no good and that you will see this and reject me. So I play my games, my desperate pretending games with the facade of assurance on the outside and a trembling child within. And so begins the parade of masks—the glittering but empty parade of masks, and my life becomes a front. I idly chatter

to you in the suave tones of surface talk. I tell you everything that is really nothing. Nothing of that which is everything of what is crying within me. So when I am going through my routine, do not be fooled by what I am saying. *Listen carefully.* Please hear what I am not saying . . . what I would like to be able to say, what, for survival I need to say, but I can't say. I dislike hiding, honestly I do. I dislike the superficial phony game. I'd really like to be genuine, spontaneous, and *me;* but you have got to help me. You've got to help me by holding out your hand, even when that is the last thing I seem to want or need. Only you can call me into aliveness. Each time you are kind, gentle and encouraging . . . Each time you try to understand because you really care, my heart begins to grow wings . . . very small wings . . . very feeble wings . . . but wings. With your sensitivity, sympathy, your power of understanding, I can make it. You can breathe life into me. I want you to know that. I want you to know how important you are to me. How you can be a creator of the person that is me, if you choose to. Only you can wipe away from my eyes the blank, starved stares of the breathing dead. Please choose to. You alone can break down the wall behind which I tremble. You alone can remove my mask. You alone can release me from my shadow world of panic and uncertainty . . . from my lonely prison. So do not pass me by. Please! do not pass me by. It will not be easy for you. A long conviction of worthlessness builds strong walls. The nearer you approach me, the blinder I strike back. It's irrational. I'm told that love is stronger than the strongest walls. There lies my hope. Please try to beat down those walls with firm hands . . . with gentle hands, for a child is very sensitive and I am a child. Who am I, you may wonder; I am someone you know very well. I am everyman you meet. ◄

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The Sad Saga of the Zany Sextet of Super Specialists

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NOWADAYS, more and more, the obviously absurd hyperbole of just yesterday has the pullulating penchant for becoming the obfuscating obloquy of today. Thus, the wry jest of my student days:—"The GENERALIST learns less and less about more and more until he winds up knowing nothing about everything. Now, the SPECIALIST learns more and more about less and less until he winds up knowing everything about nothing." All this preamble leads me squarely to a couple of recent cases that other doctors had asked me to see.

Lovely Linda (Usual Disclaimer) was a girl born possessing everything. An impeccable WASP ancestry, doting—even if foolish—parents, fantastic wealth, great intelligence, outstanding charm and beauty, the belle of the ball, The Debutante of the Year . . . And, yet, eventually, just plain unlucky! The surfeit of super specialists submerged her "spurlos versenkt" while she was attaining a glowing, healthy 30 years! But let us not outrun our story.

My own entry into lissome Linda's life was one of those crazy concatenations of incredible coincidences. Linda, a recently happy bride, had gone skiing at an Adirondack resort. She had slipped and plunged kerplunk into a snow bank. One ski had snapped in such fashion that a broken piece had smacked her smartly over the upper abdomen. She sat bolt upright; the tap on her belly did not distress her at the moment. The limbs appeared to be uninjured. With a minimum of help she found her way back to her plush lodge.

Nevertheless, that very evening Linda began to complain of increasing pains in her upper abdomen and back. The solicitous bridegroom decided to play it safe and rush her right back to New York City. Very early the next morning their family physician made a house call. He was alarmed at what he found; he had her taken immediately to the voluntary hospital on whose staff he was an attending. A most thorough work-up was started: stat!

This excellent young M.D. had been Linda's high school classmate. As the clinical and laboratory picture began to unfold, he became thoroughly disturbed. This was especially so as the upper abdominal tenderness became ever more acute and the laboratory data seemed rather inchoate. The WBC was over 15,000 with a marked shift to the left. The flat plate of the abdomen was not suggestive of anything, even if the roentgenologist did point at the first jejunal loop and did mutter anent "suggestion of a segmental paralytic ileus resembling an early 'sentinel loop'." The DD included too many unpleasant possibilities: ruptured viscus, biliary colic, nephrolithiasis, perforated ulcer, acute pancreatitis, acute appendicitis—just a host of things.

Also, Linda's condition seemed to be worsening rapidly. The BP was dropping, the pulse rate was rising: she seemed to be going into hypovolemic shock! X-rays of the thoracic and lumbar spine appeared to rule out a slipped disc secondary to Linda's pratfall. And then: the serum amylase report came up. It was well over 1,200 Somogyi units! A quick check of an hour's urine output showed more than 400 units of the same amylase! This made the diagnosis of ACUTE PANCREATITIS just as certain as anything in medicine can be. That rap on Linda's tummy was the obvious etiological factor. It was still too early to look for Cullen's or Turner's signs. The astute young attending medico had been at a recent CPC at which I, also, had been present. The presumed ruptured duodenal ulcer for which the patient had been operated turned out to have been hemorrhagic, necrotizing pancreatitis.

It is a long muted item of my past that, while a resident at Cook County Hospital of Chicago, I had



performed some autopsies on pancreatic pseudocysts, etc. My late chief, Dr. Sidney Portis, had directed me to dig up the pathology files of the hospital and do a review of the then extant literature. Our series was presented at a society meeting (which one??). For all I know now, it may still be by far the largest collection still on record. Anyhow, at the CPC mentioned I was called upon for a few remarks. SO: the bright young internist of today called old me on the phone. Could I come but immediately? I was in the hospital; I listened. Dropping everything, I was on the scene within a half hour.

My brilliant young colleague's work-up of just that morning was a model of medicine at its very best. My only suggestions were:

1) STAT, start blood transfusions, steroids, naso-gastric suction and give the intensive therapy that should abort the impending hemodynamic shock which just could lead to a speedy exitus. (Adequate, *CONSERVATIVE* management saves up to 90% of the patients. Survey *REVERSES* the figures.)

2) Do a confirmatory abdominal paracentesis for amylase and lipase levels of the fluid which we would expect to aspirate. Repeat as needed.

I received a heartfelt, "Thank you, Dr. L.! and, by the way, charge the father there"—pointing—"your maximal fee: doubled! The husband is in a bit of a daze and Papa has taken over. You sure don't go to HIS church and to him only money gages services rendered; it has that command imperative."

Well! Not much of my time had been spent. I had but little to add; the magnificent management really only required an order to get rolling. We both went over to the parents and the distraught husband. My colleague's brisk and lucid exposition needed only a few confirmatory words from me. I did emphasize the need for immediate drastic therapy scheduling. When asked, I did claim a (to me) hefty three-figure check. So? Why this long explication?

Of course you've heard of that certain road paved with good intentions? Only two days later, I practically collided with my young M.D. friend in the corridors of the selfsame hospital. He was so utterly woebegone, wretched and bedraggled that I all but failed to recognize him. What gave?

"Linda just *died* at the Orthopedic Hospital!"

"But . . . How did she get *there,* of all inappropriate places? On whose service?"

My bewildered sympathy was just the stimulus to break the dam. The whole pitiful tale just poured out. It seems that Linda's papa was unhappy with the diagnosis propounded by my colleague and so emphatically supported by me. Just the previous month a close friend of his had had a pratfall very similar to Linda's (but without that blow on the abdomen). The x-rays had been negative. Too late, it was demonstrated that a disc *had* slipped; the cord had been compressed. This very close associate was now a helpless paraplegic. Papa was *NOT* going to permit that disaster to overtake his daughter. He insisted on calling another distinguished friend who was professor emeritus of orthopedics at several great city hospitals. The great man would see Linda *ONLY* at *HIS* hospital. So: Papa signed Linda out and transferred her forthwith to that hospital. Never mind that my young friend was screaming his anguish, "Linda just cannot wait for her treatment! She is going into shock already."

"Well, you don't HAVE to be her doctor! She's going to a Real Honest to Goodness Hospital to be treated by a famous doctor. Forget your fancy gobbledygook you've been handing us! And that Jewish pal of yours! Who-he? Bah!"

So: An intensive, all-night procession of surgical luminaries went streaming through Linda's bedroom in the Critical, Intensive Care Unit. There was the Professor Emeritus who ordered a whole host of tests; the "ordinary" general surgeon, the neurosurgeon, the orthopod specialist on back trauma, the plastic synovial-repair-only g e n t l e m a n (there are few of them). The whole pride of a half-dozen lions huddled together jointly and finally decided on stat exploratory laparotomy.

By seven a.m., poor Linda was lapsing into coma; BP was 50/0; pulse thready and all but imperceptible at some 160/minute; respirations shallow and rapid; cyanosis deepening—do I have to elaborate? At *that* time she did receive catecholamines, I.V. fluids (pushed and piggy back), oxygen via intubation and forced. She hardly needed any anesthesia; the abdominal incision was quickly made; the milky chyle was aspirated and—en passant—a sample sent for amylase testing. The lesser abdominal cavity was explored. The pancreas was, indeed, seen to be terribly edematous and hemorrhagic necrosis was discernible to the naked eye. The "All Star" surgical team closed up in a hurry and rushed the dying woman back to recovery. In spite of stimulants galore, oxygen by continuing intubation, I.V. of blood and everything imaginable . . .

"What more is there to say?" My poor colleague just leaned on my shoulder and wept unabashedly.



"They battled all that day and night. It was just this morning that the EEG finally flattened out—the heart stopped and failed to respond to electric shocks. Why? Oh, why did this splendid woman have to die?? She had so much to live for. They—these so and so 'brilliant' specialists did not even bother to ask for her findings at *this* hospital! How stupidly conceited can a pride of these super-duper 'experts' be?"

I'm supposed to be a garrulous s.o.b. but I just could not think of anything consoling to say. All I did do was to pat him gently on the back, take him to an empty cubicle in the ER, silently abscond with a pint of raw whiskey and (with some dilution) force it down his guliet. I stretched him on the bed there, left an orderly to watch him and called his wife to come and get him. The young ever-so-prim-and-proper teetotaler was out cold! The entire *SAGA OF THE ZANY SEXTET OF SUPER SPECIALISTS,* the doltish papa and the dazed husband became a dreadful delirium: consigned to the *VERBOTEN* realm of the Undiscussable.

As happens so often, it was only a few weeks later that I was hurriedly called to see a gentleman who had just recently moved into the Co-op apartment building in which I have been residing since its construction an odd-dozen years back. His family physician was unavailable that evening. The patient had been put on chlorothiazides just the week before. The frantic wife was telling me that her husband had started to become drowsy and incoherent in the late afternoon; by the time I saw him, he appeared to be almost comatose. The symptoms and signs were mostly in the epigastric region. The BP was normal even if the pulse was well over 100/m.

Following the lovely Linda episode, I had done an extensive search of the acute pancreatitis literature. Was I? Or was I not being confronted by an individual developing an acute pancreatitis consequent to the ingestion of thiazides?*

Well! I went on that rather esoteric assumption, sent the gentleman to the hospital and started the ball arolling while calling the regular G.P. whose patient the man was. And: I was really delighted to see my hunch pay off. A lot of folk now have the idea that I'm really a just great diagnostician . . .

Finally: I'm awaiting that *mysterious,* inevitable, third case. I wonder what form it will take . . .

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*Johnson, D.H.; Cornish, A.L.: Acute Pancreatitis in Patients Receiving Chlorothiazide, *JAMA* 170:2054 1959.

BIBLIOGRAPHY ON ACUTE PANCREATITIS

It is rather extensive—and growing. First, we have the standard texts such as:

1. *Medicine,* Keefer & Wilkins, 1970, pages 570-580 (rather elementary for a start).
2. *Merck Manual,* 12 ed., pages 703-706.
3. Cecil-Loeb, 13 ed., pages 1312-1319.
4. Price, 10 ed., pages 582-585.
5. Harvey's, 17 ed., pages 921-922.
6. Harrison, 5 ed., pages 1096-1110.
7. *Patient Care,* May 1972, Pancreatitis.
8. *Internist Observer,* vol. 10, no. 5.

And real esoterica such as:

9. Diamond, M.E., Hyperglycemic, Hyperosomolar Coma in Pancreatitis, *N.Y. State J. Med.,* July 1972, pages 1741-1742, etc., etc.

Also, a most instructive article:

10. Crampton, et al.: Production of Myocardial Depressant Factor (by the Pancreas) Following Acute Myocardial Infarction. *Am. J. Cardiol.,* Feb. 1972, page 257-on. ◄

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Recent Developments in Treatment of Childhood Cancer—I

ARNOLD J. ALTMAN, M.D.
ROBERT L. BAEHNER, M.D.
Indianapolis

NEOPLASTIC disease currently is second only to accidents as a leading cause of death in the 1-14 year age group. It has an incidence of 6.7 cases/100,000 population and results in approximately 4,000 deaths annually in the United States.[1] As great a tragedy as these figures represent, it is an even greater tragedy that many of these deaths are preventable. As will be brought out in this article, recent advances in the field of oncology have resulted in a markedly improved outlook for children with many forms of cancer; however, these advances can be translated into improved survival statistics only if the primary physician detects cancer as early as possible, prevents early mortality from the complications of the neoplasm, and then allows his patient to be treated by a center specialized for the care of children with neoplasia.

ROLE OF THE PRIMARY PHYSICIAN IN CARE OF THE CHILD WITH A MALIGNANCY

Since the primary physician is generally the first person to evaluate and treat the child, his role is frequently critical in determining whether his patient will survive.

The clear correlation of survival with extent of disease at the time of diagnosis makes it imperative that malignancy be detected in its very early stages. For this reason, the primary physician must be alert to the possibility of cancer in any child with appropriate presenting complaints. Such complaints may be of three varieties[2]:

1) Related to the tumor itself—any mass not diagnosable by the characteristics of its location (thyroglossal duct cyst, dermoid cyst, etc.) should be considered potentially malignant. Such lesions should not be watched with the expectancy that they will disappear (except for inflammatory lymph nodes and hemangiomas). Generally the only way to prove or disprove malignancy is to biopsy the lesion.

2) Symptoms referable to tumor—e.g., unexplained bleeding from any site, localized pain or discomfort, obstruction to flow through body orifices, organ dysfunction.

3) Nonspecific symptoms—persistent low-grade unexplained fever, irritability, failure to thrive, weight loss. In this category one must also be aware that the symptom complex frequently characterized as juvenile rheumatoid arthritis (JRA; fever, joint pains, splenomegaly, lymphadenopathy) may be produced by occult malignancy and the diagnosis of JRA should not be accepted until appropriate studies to rule out malignancy have been performed.

Once a malignancy has been dianosed, initial management must be directed to complications of the disease if the patient is to survive long enough for specific antineoplastic therapy to be instituted (Table I). Anemia, bleeding and infection must be dealt with in a vigorous, effective manner. After appropriate cultures are taken, antibiotic coverage with gentamicin, methicillin and carbenicillin is begun if sepsis is likely present. A frequently unrecognized but potentially fatal problem is an elevated uric acid level resulting from breakdown of

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The second portion of this article, concerning Hodgkin's Disease, Neuroblastoma, Rhabdomyosarcoma and Wilms' Tumor, will appear in a subsequent issue, together with the references for both parts.

TABLE I

Management of Life-Threatening Problems In Children With Malignant Disease

Anemia:	Transfuse with packed RBC (10 cc/kg) if hgb is < 7.0 or anemia produces signs of congestive heart failure.
Hemorrhage:	1) Local pressure to bleeding site if possible. 2) Determine etiology of bleeding diathesis (thrombocytopenia, liver dysfunction, disseminated intravascular coagulation, vitamin K deficiency, etc.) and institute appropriate corrective measures (platelet transfusion, fresh frozen plasma, or heparinization) after consultation with hematologist. 3) Avoid intramuscular injections and drugs which interfere with platelet function (e.g., salicylates, antihistamines, phenothiazides, glycerol guaiacolate) as they may accentuate bleeding diathesis.
Fever:	1) Careful physical examination for site of infection. 2) Appropriate x-ray studies. 3) Cultures (throat, sputum, blood, CSF, urine). 4) If patient is severely granulocytopenic, debilitated or immunosuppressed, parenteral antibiotic therapy* consisting of gentamicin (3-5 mg/kg/day-max. 240 mg/day), methicillin (200-400 mg/kg/day-max. 12-16 gm/day) and possibly carbenicillin (400-500 mg/kg/day-max. 20 gm/day) should be started while awaiting results of cultures.
Hyperuricemia: (serum uric acid > 6 mg/100 ml)	1) Intravenous hydration (3,000 ml/M^2/day). 2) $NaHCO_3$ (3-4 gm/M^2/day)-to raise urine pH to 7.0-7.5. 3) Allopurinol (10-20 mg/kg/day).

*Modification of drug dosages (especially gentamicin) is indicated if renal failure is present. Consult afficial package circulars ar Physician's Desk Reference for details of administration and side effects.

DNA from the rapidly proliferating tumor cells. Since uric acid may precipitate in renal tubules in an acid environment and lead to renal failure, this potentially life-threatening problem must be recognized and treated effectively. Treatment consists of intravenous hydration, sodium bicarbonate therapy and allopurinol (provided that the patient is not already in renal shutdown). If the patient is already in renal failure, appropriate measures such as fluid restriction and possibly dialysis should be considered.

When these problems are under control and the patient is in a stable condition, strong consideration should be given to transferring him to a center where all the latest diagnostic and therapeutic modalities are available, in order to ensure that he has the best chance of survival. However, even when the child is under the care of the cancer center, constant communication must be maintained with the primary physician. Follow-up examinations and administration of chemotherapy are frequently undertaken by the family physican, once evaluation for nature and extent of tumor is completed and the optimal course of therapy decided upon.

ROLE OF THE CANCER CENTER IN CARE OF THE CHILD WITH A MALIGNANCY

The day is past when the "compleat physician" can diagnose and manage cancer of any degree of complexity entirely on his own; optimum therapy requires a judicious blend of surgery, radiation, chemotherapy and immunotherapy. A cancer center must provide all these disciplines in sufficient breadth and depth to ensure that a program of maximum quality care can be formulated and carried out. Usually such a center functions as part of a regional university hospital, a large teaching hospital or an independent cancer research institution. At the center the management program for each patient is usually determined at an organized therapeutic planning session where members of each discipline meet face to face in order to lay down guidelines for the course of treatment to be adopted. Such therapeutic regimens are most effective when instituted at the time of initial diagnosis of malignancy, for this is the time when we have the best chance for cure. The physician who utilizes the cancer center as a "court of last resort" when the patient has failed to respond or has relapsed on a suboptimal or outdated regimen has done his patient a great disservice. Likewise, the physician who diagnoses malignancy and decides to treat with a palliative regimen on the premise that "they all die anyway" is pursuing a course that is no longer medically or morally acceptable.

Approximately 100 children with malignancies are referred to the Hematology-Oncology Unit at James Whitcomb Riley Hospital for Children annually; about half of these children have leukemia and half have solid tumors.

Acute Lymphocytic Leukemia (ALL)

Untreated, patients with ALL have a median survival of three months and fewer than 1% survive for one year. However, it is currently possible to achieve a median survival (free of disease) for five years in this disease by utilization of the following principles of management[3]: 1) rapid induction of remission with vincristine and prednisone, 2) prophylactic central nervous system treatment with irradiation and/or intrathecal methotrexate, and 3) continuous maintenance therapy with two or more antileukemic drugs.

1) *Rapid induction of remission*

The combination of vincristine and prednisone produces complete remission of disease within 28 days in approximately 90% of patients with ALL.[3] This regimen has the advantage of not only being quite effective, but it also has a remarkably low toxicity in comparison with other chemotherapeutic agents for malignant disease. The major side effects of vincristine are: peripheral neuropathy, hair loss (usually reversible), abdominal and jaw pain, and paralytic ileus. Prednisone therapy can result in hypertension, excessive weight gain, diabetes, gastrointestinal ulceration, and cushingoid facies. Significantly, neither of these drugs causes bone marrow suppression, a great advantage in treating patients whose blood counts are already suppressed by the basic disease process.

2) *Prophylactic central nervous system treatment*

When patients with ALL have prolonged remission of disease (1-2 years), over 50% of these remissions are terminated by the development of central nervous system (CNS) leukemia, usually in the form of leukemic meningitis.[4] The development of CNS leukemia probably means that the patient is no longer curable since bone marrow relapse usually follows within 2-3 months.

Postulating that CNS leukemia resulted from persistence of leukemic cells in the meninges (where they were protected from chemotherapeutic agents by the blood-brain barrier), Aur et al.[5] designed a protocol to eradicate leukemic cells in this so-called "sanctuary" area at a time when the patient was still in complete remission. They found that radiotherapy (2400 rads) to the cranio-spinal axis or a combination of cranial irradiation with intrathecal administration of methotrexate could lower the incidence of CNS leukemia to less than 10%. Moreover, this resulted in a much lower incidence of bone marrow relapse and a significantly longer disease-free survival time. It is from these studies that the optimistic prediction of a 50% disease-free five-year survival time for children with ALL derives.

Complications of such therapy includes: alopecia (usually reversible), growth retardation, bone marrow suppression and a transient mild encephalopathy accompanied by lethargy, vomiting and low grade fever.

3) *Maintenance therapy*

The rationale behind this phase of therapy is that combinations of drugs with different modes of action produce additive destruction of leukemic cells, leaving fewer to develop resistance. Moreover, cells partially sensitive to one agent might be highly sensitive to a combination of drugs.

Combination chemotherapy with two or more drugs appears to be superior to sequential or cyclical administration of single agents. Most protocols include methotrexate, 6-mercaptopurine, and cyclophosphamide given in varying combinations and sequences.

Possible long-term complications from chemotherapy include hepatic and pulmonary fibrosis, osteoporosis, sterility, growth suppression and bone marrow suppression. Of major importance is the development of immunosuppression, frequently predisposing the patient to a variety of overwhelming infections with otherwise innocuous organisms. A recent report[6] states that 16% of leukemic children are currently dying (while in complete remission of their disease) because of infections with such organisms as fungi, pneumocystis carinii, cytomegalovirus and varicella.

Now that a significant number of children with ALL are surviving for a prolonged period of time, the question has arisen as to how long maintenance therapy should be continued. In some centers all therapy is being discontinued after two to three years of complete remission. Although data are incomplete at this time it would appear that small numbers of relapses occur in these patients. However, relapse even after eight years or more of remission has been documented. Therefore it seems premature to consider children who have remained in remission for two to three years after medications have been discontinued as "cured." However, it does appear that as many as 25% of children with ALL may soon achieve this designation if they are allowed the benefits of the newer forms of treatment. Tragically, however, only 15% of children afflicted with ALL currently are being given the benefit of these recent advances at major cancer centers.[7]

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So said a telegram sent to the governor, supposedly from a concerned citizen by the name of Watson. But in fact, Watson had nothing to do with the telegram. It had been sent by a local manufacturing firm, which had simply picked his name out of the telephone book.

Watson later found out about the telegram, and filed a damage suit against the company "for taking my name in vain." And a court ruled that he did indeed have good grounds for complaint. The court said:

"(The company) appropriated, without the plaintiff's consent, his name, his personality, and whatever influence he may have possessed. This they had no right to do."

This case illustrates the growing recognition of the right of privacy as a legal doctrine. Often called "the right to be let alone," it has already been applied in a wide variety of situations.

Another example arose when an obstetrician, summoned to a woman's home to deliver her baby, brought a young man into the bedroom with him.

The woman assumed that the stranger was some sort of medical aide. Only afterward did she learn that he was merely a personal friend of the doctor. She sued for an intrusion on her privacy, and the court upheld her claim.

Of course, the right of privacy is not unlimited. It must be reconciled with other rights with which it may conflict. Thus:

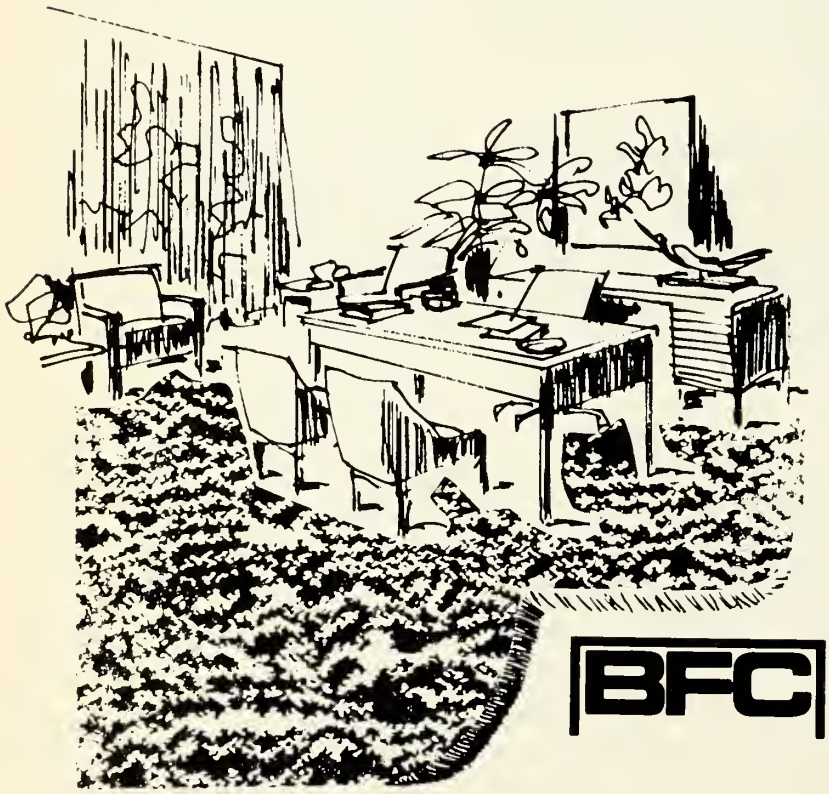
A man who was mugged on a downtown street objected to the publicity that appeared in the local press. He argued in a court hearing that, as a private individual who had done no wrong, he was entitled to the shelter of the privacy doctrine.

But the court pointed out that whether he liked it or not, he was "newsworthy"—a legitimate object of public interest. The right of privacy, said the court, did not outweigh the freedom of the press guaranteed by the Constitution.

A public service feature of the American Bar Association and the Indiana State Bar Association. Written by Will Bernard.

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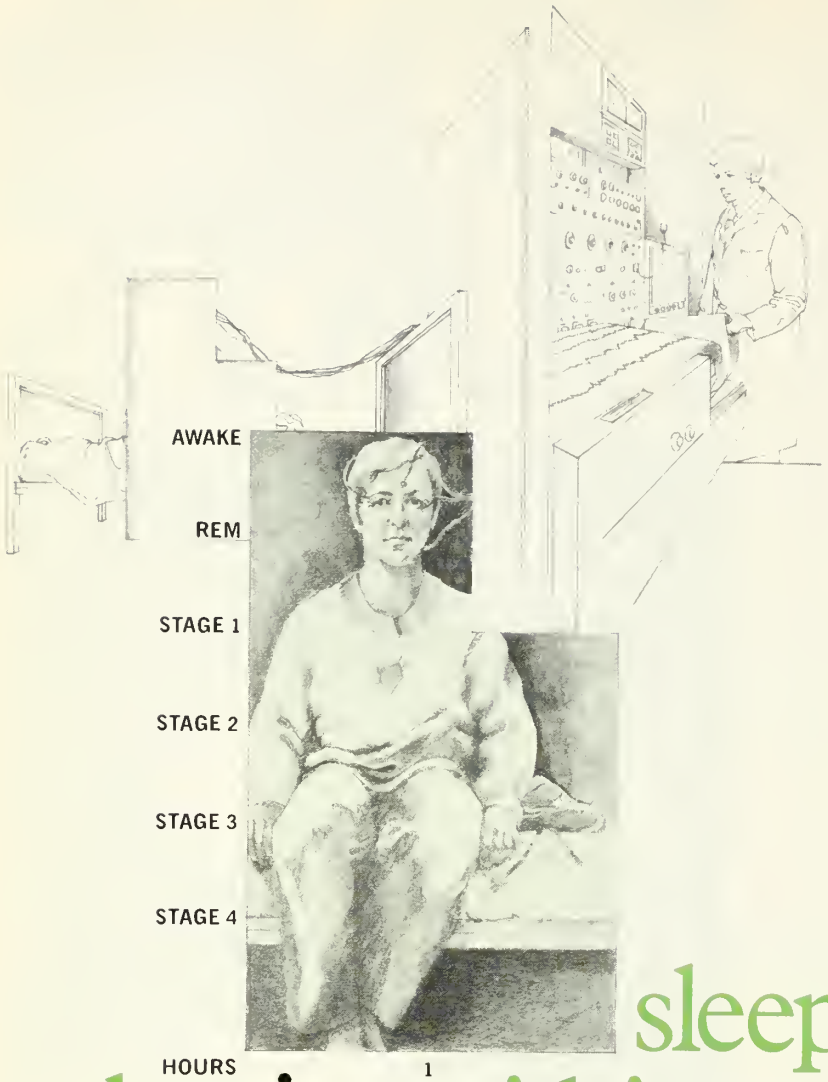


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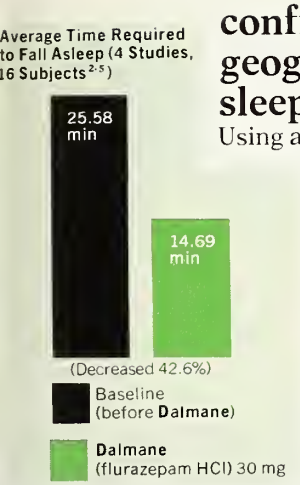


sleep begins within 17 minutes, on average ... an initial benefit of

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proved by a 22-night clinical study of insomnia patients in the sleep research laboratory and at home[1]

Three insomnia patients selected for difficulty falling asleep were administered Dalmane (flurazepam HCl) 30 mg for 14 consecutive nights. Placebo was given for four nights prior to and four nights after Dalmane. Physiologic tracings on Dalmane nights 1-3 showed sleep induction time averaged 13.90 minutes; on Dalmane nights 12-14, 18.80 minutes. Combined average for the 6 monitored drug nights was 16.35 minutes.[1]



confirmed by clinical studies in four geographically separated sleep research laboratories[2-5]

Using a 14-night protocol involving eight insomniac and eight normal subjects, four studies confirmed the sleep-inducing effectiveness of Dalmane (flurazepam HCl) and the reproducibility of this response. On average, one 30-mg capsule induced sleep within 17 minutes. In all these studies, Dalmane induced sleep rapidly, reduced nighttime awakenings, and provided 7 to 8 hours of sleep without repeating dosage[2-5]

Dalmane (flurazepam HCl) induces and maintains sleep, with relative safety

Dalmane is generally well tolerated; morning "hang-over" has been relatively infrequent. While dizziness, drowsiness, lightheadedness and the like have been noted most often, particularly in the elderly and debilitated, physicians should be aware of the possibility of more serious reactions, as noted below.

Before prescribing Dalmane (flurazepam HCl), please consult Complete Product Information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.

Contraindications: Known hypersensitivity to flurazepam HCl.

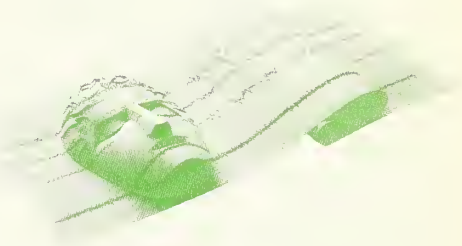
Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, have also been reported in rare instances.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.



when restful sleep is indicated

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One 15-mg capsule *h.s.* — initial dosage for elderly or debilitated patients.

- induces sleep within 17 minutes, on average
- reduces nighttime awakenings
- sustains sleep 7 to 8 hours, on average, without repeating dosage

REFERENCES: 1. Kales A, *et al*: *Arch Gen Psychiatry* 23:226-232, Sep 1970
2. Karacan I, Williams RL, Smith JR: The sleep laboratory in the investigation of sleep and sleep disturbances. Scientific exhibit at the 124th annual meeting of the American Psychiatric Association, Washington DC, May 3-7, 1971
3. Frost JD Jr: Data on file, Medical Department, Hoffmann-La Roche Inc, Nutley NJ
4. Vogel GW: Data on file, Medical Department, Hoffmann-La Roche Inc, Nutley NJ
5. Dement WC: Data on file, Medical Department, Hoffmann-La Roche Inc, Nutley NJ

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Before prescribing, see complete prescribing information in SK&F literature or *PDR*. The following is a brief summary.

Indications: Edema associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. Also, mild to moderate hypertension.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired. Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, descreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Rarely, necrotizing vasculitis, paresthesias, icterus, pancreatitis, and xanthopsia have occurred with thiazides alone.

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Studies have demonstrated that two prime reasons patients drop out of hypertensive therapy are: (1) the patient failed to understand directions, and (2) the regimen was overly complicated.* Dosage is simple with 'Dyazide', easily understood, once or twice daily, depending on response. There's no need to complicate the regimen with potassium supplements or unwieldy potassium-rich diets.

*E.D. Freis: The Modern Management of Hypertension, V.A. Information Bulletin, 11-35.

TO KEEP BLOOD PRESSURE DOWN AND KEEP POTASSIUM LEVELS UP

Services for Crippled Children

KAY S. BROWNE, M.D.
Indianapolis

WE hope, in writing this article, to help doctors in Indiana better understand our program and to thereby improve cooperation and services available to handicapped children in Indiana.

Crippled Children's Services exist in all states as established in 1936 under Title V of the Social Security Act. The federal legislation is somewhat broad and, consequently, programs differ greatly from state to state. Every state receives federal Title V monies for the program, the amount determined by population and economic situation. A set percentage of this money must be matched within the state in order to receive the total federal amounts available.

Indiana is one of the few states that has established its Crippled Children's Services within the State Welfare Department. The funds for matching come from county welfare funds. The federal funds are used for administering the program. Billing on crippled children is primarily handled through the county welfare department offices.

Eligibility for the program is determined on both a financial and medical basis. A child's family's resources are budgeted by a caseworker when initial application is made. The financial requirements are somewhat strict and vary slightly from county to county because of differences in available tax dollars and differing welfare board attitudes. Medical eligibility is determined at the state level by the Medical Director. Essentially, all children with extensive medical needs on an ongoing basis are medically eligible for Crippled Children's Services. The primary exceptions to this include diagnoses that would be considered primarily the responsibility of other state or local agencies. We hope soon to provide on request a comprehensive list of diagnoses eligible.

Diagnoses are established prior to coming onto the program. If a child's problem has not been sufficiently delineated, then an appointment for evaluation may be scheduled at a treatment center prior to acceptance.

In the near future, we hope to advertise periodic, free, drop-in clinics intended to screen children for crippling problems and to pick up children that have not had previous help.

Practically all of the care provided under auspices of our program is through our treatment centers. These are located at Indiana University Medical Center in Indianapolis, and in Evansville, Jeffersonville, Richmond, South Bend, Fort Wayne, Gary and Michigan City. We limit treatment facilities because we are federally required to oversee and authorize care we pay for and because the majority of children on our program have need of highly specialized and coordinated care. There is no reason why that child cannot be seen for routine care by its previous physician, if it is understood that control of its medical plan will rest with the treatment center physicians, but this service cannot be reimbursed by Crippled Children's Services. The treatment center physicians are expected to interact with and inform the child's original physician. In cases in which a child is very sick or is in need of very frequent emergency or drop-in care and lives a distance from a treatment center, a specific local doctor will be authorized to provide this care associated with the crippling condition. The authorization can be given by the Medical Director or one of the outlying treatment center pediatricians. It should be requested through the county welfare department so that their cooperation in paying is ensured.

On occasion, a child also will be allowed to remain under the care of its local doctor or previous medical center if it is felt that care has been equal to that available through the treatment center and if the child's care or health would be jeopardized by transfer. Requests for such specialized assignment should be made through the Medical Director.

Each family will be visited at least yearly by a caseworker to ensure ongoing financial eligibility. In addition, most children's homes are visited much more frequently by the local public health nurse. The state office provides a consultant staff of six master's degree social service workers and seven bachelor's degree nurses with comprehensive public health experience who are available on a statewide basis to caseworkers, county welfare departments, public health nurses and boards of health. These consultants have the responsibility of explaining the program, being ombudsmen for families under our services, teaching field nurses about special needs of the complicated children on our program, and acting as statewide liaison between the state department and counties. They are available to local medical personnel on an ongoing basis. The names and addresses of those serving each area are available on request.

Community physicians can help the Crippled Children's Program in certain ways: When children with severe medical conditions whose families are totally unable to defray expenses come to a doctor's atten-

tion, they should immediately be referred to the local welfare department to make Crippled Children's application. When requests for medical information come from Crippled Children's caseworkers, this should be promptly given to the welfare department. Physicians should promptly and completely fill out congenital deformity reports. (We use these for case finding on our program.) When problems arise with the program, calls should be placed to the Medical Director, Crippled Children's Division, State Department of Public Welfare, Indianapolis (317-633-5764), or to one of the local consultants.

It is our hope to work cooperatively with the medical community. We would hope to utilize increasingly more of the available medical manpower in helping crippled children in Indiana. ◄

100 N. Senate Ave., Rm 701
Indianapolis 46204

165 Indiana Physicians Win 1973 CME Award

In August the Executive Secretary, President and Coordinator of Continuing Medical Education at Indiana State Medical Association received two print-outs from AMA's Department of Continuing Medical Education, listing 165 Indiana recipients of the 1973 AMA Physician's Recognition Award.

The Award is a voluntary CME program designed to improve physician competence and recognize physicians active in CME. In 1973, 12,488 physicians qualified for the Award; with 23,986 now holding currently valid certificates.

ISMA plans to use this information, made available only to state medical and medical specialty societies, in a number of ways:

1. To verify that individual physicians qualified for the Award;
2. To recognize physicians for personal CME activities;
3. To document professional leadership in CME for legislative committees and licensing agencies—demonstrating that a mandatory CME requirement is unnecessary;
4. To help plan and evaluate current CME programs; and
5. To encourage membership in ISMA.

ISMA members should be aware of the many advantages to earning the Award. Those who qualify by completing 150 hours of CME every three years, 60 of which must be earned in AMA-approved, Category I credit, use the Award for:

a) Reviewing, evaluating, planning their personal CME program;
b) Completing administrative reports, tax records, etc.;
c) Maintaining hospital staff privileges, status as a consultant or an academic appointment;
d) Documenting participation in CME as required or recommended by their:
   1. Group practice
   2. Peer review of self-assessment programs
   3. Recertifying body
   4. Relicensing board
   5. Local, state or medical specialty society for continued membership

For further information about the Award program, contact ISMA or AMA's Department of Continuing Medical Education, 535 N. Dearborn, Chicago, IL 60626.

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Problems Abound in Britain's National Health Service

Britain's National Health Service has always been popular with the masses because it makes it possible for any patient to visit the doctor at any time, even as often as once daily. In fact, enough Britishers visit the doctor often enough and call him out on house calls sufficiently to reduce the time he may spend with each patient to a few minutes.

It is a wonderful system for those who are in good health and enjoy visiting the doctor. Those who are actually sick and require specific treatment are dependent on the ordinary doctor's instinct for diagnosis and his ability to identify the really sick and send them to see a specialist or consultant at the hospital.

Ordinary doctors don't usually go to the hospital. Most of the genuine medical practice is done by hospital consultants. Ordinary doctors take care of the ailments that get well by themselves. They also act as signposts for the patients who require any sort of medical skills.

None of the British doctors get paid very much; those with a panel are obliged to sign on as many as several thousand patients in order to make a living on the capitation method of remuneration.

The hospital consultant, who would be called a specialist over here, does not get much of a salary, either. However, up to now, the consultant has been privileged to do private practice and collect fees on a regular private practice basis. Also, up to now, the hospital consultant has been able to admit his private patients to the hospital with which he is connected. The British have what they call nursing homes which are fairly well equipped private hospitals. There are not many of these and they are all relatively small, but consultants use them for private patients.

Over the years many Britishers who could afford to do so have subscribed to medical insurance which is designed to pay their medical expenses, or a good part of them, as private patients. At one time this was the fastest growing example of medical insurance in the world. It is still very popular. These people, of course, pay in taxation their share of the National Health Service and also pay for their own private care by carrying insurance coverage. This shows how popular the NHS is with those who can afford to avoid it. Most of the British Ministers of Health, when they were seriously ill, have forsaken the NHS, and have been cared for as private patients.

In view of all this one might say that the last change of government in England has created a rather nasty kettle of fish—a sticky wicket, so to speak, as far as good private medical service is concerned.

The socialists have decided that there is too much of private practice. Apparently they also think the consultants are too much in the velvet with their private practice fees. There is talk of denying the admission of private patients to NHS hospitals. This will do it, since the nursing homes are not able to handle all the private patients.

There are several crises in the NHS.

The consultants are unhappy and are threatening to leave the NHS or even leave Britain. Since they are the doctors who have been caring for most of the really sick people, the situation is precarious. The Labour government, however, still insists it will do away with private practice.

Aside from the above, the NHS has found another problem—the Service needs 500 million pounds to finish the year and there is no money available.

At the last meeting of the British Medical Association there were expressions of "concern about declining standards of medical care." Since the NHS has now been in operation for 28 years, these concerns are probably not expressed by doctors who remember the better way. The concerned doctors are those who have grown up in the Service; they have never known anything else and

are now aware of its poor quality.

Two London hospitals (Guy's and The London) have patient waiting lists which exceed 3,000. Five other hospitals each have lists of more than 2,000. Doctors continue to emigrate and now they say that nurses are doing the same.

This is all pretty sad, but not as sad as the state that American medicine seems to be approaching. With such a deplorable example of socialized medicine in a great English speaking nation one would imagine that warmed-over socialism would not have a chance in America.

However, it does. The Congress has just intimated that it will not pass a law for national compulsory health coverage this year. The reason is not that Congress opposes such a system. The truth is that the Congressmen have not been able, so far, to decide the details of the American scheme. Apparently they are all in favor of some form of compulsory government interference but need more time to determine the method by which they plan to destroy the best medical service in the world.

They now have, thanks to the AMA, a fairly good chance of making PSRO stick. All they need is the national health insurance law to produce a situation which in a few years will rival what the British call "National Health Service."

No one should lament the Congressional delay in prosecuting a health insurance law. We should hope for more delays and more disagreement in Congress. Perhaps, after a few delays, enough politicians will realize that there is nothing that the federal government can do to improve what is the best distributed and best practiced system of medical care in the world.

Guest Editorials

Anger

THE late N. C. Gilbert said on many occasions that every emotion, except pity, could trigger a heart attack. How true. Anger is, perhaps, the most lethal of human emotions. This was best popularized by John Hunter who said that his "life was in the hands of any rascal who chose to annoy and tease him." And there can be no doubt that his death was hastened by the violent disagreements he had with his colleagues at St. George's Hospital. He died on October 16, 1793, following a board of governors' meeting of St. George's Hospital at which a colleague made him the brunt of some disparaging remarks.

Anger can be an individual or a family affair, or a racial, national, or international trait. As an intense emotion, it most certainly overstimulates the brain and the harm comes when there is no way to let off steam. Having one's say is, perhaps, the best remedy, but this is not always possible. Besides, we have already experienced the period of anger. Fighting anger with anger, however, is better than pent-up hostility because stewing about a problem is not the answer.

I believe that anger is as serious a risk factor as are cholestrol, hypertension, and cigarette smoking. Nowadays, anger is difficult to avoid considering our social and political environment. Physicians also have their share of complaints about the direction in which the practice of medicine is going. It is not easy to remain calm when buried under tons of paper work, third parties, PSRO, government rules and regulations, the use of generic vs. trade names, and the only too real threats of malpractice suits.

Things are not as they were 10, or even five, years ago. And the rules of the game are not always honest. But knowing the bad effects of anger gives the physician a head start on preventing the consequences. Professional men should be above petty jealousies and it is here that the old adage "only dogs get mad" is apropos.

The risks that follow outbursts of anger can be minimized by controlling one's temper. One way is to avoid anonymity because humans do many silly things when they think no one knows them. Every day when driving the car or eating in a restaurant we see examples of this. Dr. William B. McGrath suggests that we have our names painted prominently on the trunk or sides of our cars.

Cultivating an interest in others also tends to lessen anger. In pioneer days, there were many ways in which a person could help his neighbor. The desire to be helpful is still there. Compassion and kindness beyond the line of duty brings us back to Dr. Gilbert's observation. If we can't avoid anger, we can at least take pity on others so that each of us will benefit. Anyone who gives it a little thought will agree that with all of our other problems, we certainly do not need a dog-eat-dog world.—**T. R. Van Dellen, M.D., Editor,** *Illinois Medical Journal,* **August 1974, Reprinted with permission.**

Frozen Red Cells

UNTIL relatively recently hematologists were of the opinion that the use of frozen red cells would be limited to rare blood types and autotransfusions. The clinical advantages of frozen red cells for a large variety of specific and general medical applications are now becoming evident to surgeons, pathologists, and hematologists.

The increasing use of frozen, thawed, washed red cells has revealed a wide range of patient benefits. If such benefits are weighed against a higher cost per unit (a principal objection to the use of frozen red cells) it appears that frozen red cells can no longer be considered a luxury but rather a necessity in providing the best possible patient care for many medical problems and diseases.

It has become apparent that frozen, washed red cells substantially reduce, or perhaps even eliminate, the occurrence of posttransfusion hepatitis. This has been especially evident in dialysis services where previously an unacceptably high incidence of serum hepatitis was reported for both patients and staff. Although the extent to which freez-

ing and washing reduce hepatitis has not been statistically documented, blood banks and hospitals continue to report a marked reduction in the incidence of this disease with the use of frozen red cells.

Another major advantage of using frozen, washed red cells is the substantial reduction of leukocytes during freezing and washing. Current studies indicate that frozen red cell suspensions contain an insufficient number of leukocyte antigens to stimulate a response in the patient. There is further evidence that leukocyte-borne viruses also are removed by the process. The transfusion of frozen, washed red cells, which are essentially leukocyte free, becomes especially valuable for patients receiving multiple transfusions and for patients on dialysis anticipating kidney transplantation.

Plasma antigens and antibodies are removed during the post-thaw washing, so that the possibility of adverse reactions in patients is virtually eliminated.

Frozen red cells are particularly useful in alleviating the problems of supply and demand, thereby permitting better inventory control. At times of peak collection, frozen red cells can be stockpiled for use during periods when the supply of fresh blood is inadequate. Rare types of blood and blood for autotransfusion can also be stored indefinitely.

The quality of red cells after thawing and washing appears indistinguishable from that prior to freezing. Blood banks and hospitals in many areas are implementing frozen red cell capabilities and increasing progressively the number of units that are frozen. While frozen red cells are currently available in the Rhode Island area only to a limited extent, it is anticipated that the service will be generally available in the not too distant future.

This promising advance is a worthwhile corollary to the imminent reorganization of the blood bank system in the United States.— **S. J. Goldowsky, M.D.,** *Rhode Island Medical Journal,* **July 1974. Reprinted with permission.**

PSRO — Questions and Answers

IN an intensive campaign to promote the Professional Standards Review Organization (PSRO) program, the U.S. Department of Health, Education and Welfare has distributed a question-and-answer brochure to all practicing physicians. By posing and answering its own questions, HEW has presented a glib oversimplification of PSRO. In the interest of fairness *Massachusetts Physician* presents the following critique.

The basic surveillance, data banking, and behavior control nature of PSRO is not adequately described. No justification of the very large expenditure of federal funds, estimated at one billion dollars, for PSRO is offered. There is no acknowledgment that PSRO will in no way enhance the availability or distribution of health services, or is mention made that approving claims for payment will divert physicians and other health providers from patient care activity.

Data Banks

The very major questions of constitutional rights raised by the law are overlooked. For example, mention of the collection of data from physicians' and hospital records without the informed consent of the patient, Section 1155, is omitted. The removal of records and information from the control of physicians to whom the information has been entrusted constitutes a clear breach of Fourth Amendment protection. The assertion that private medical record information is to be "protected" in a data bank repository without mention of how such data is to be obtained constitutes an unfortunate deception.

The appeal process as described in Section 1159 by excluding matters in controversy of less than $100 creates a per-claim deductibility of that amount. Furthermore, judicial review is made available only when the amount in controversy is $1,000 or more. This is a clear breach of the Seventh Amendment as are the provisions in Section 1167 that immunity is granted from any criminal or civil liability under any federal or state law to persons providing information to PSRO's or participating in their function.

Practitioners are granted immunity from civil liability under federal and state laws as a result of their compliance with or reliance on the norms of diagnosis, treatment, and care applied by PSRO. In effect, patients are denied their right of access to due process of law in seeking compensation for injuries resulting from the activities of individuals participating in or conforming to PSRO.

A further erroneous statement is the reply to the question "When will PSRO's be established?" The statement indicates that "Until January 1, 1976, only a nonprofit professional association representing *most* of the practicing physicians in an area can qualify as a PSRO."

Omissions in Brochure

Recently published regulations pertaining to the application of agencies to become PSRO's indicate that such agencies can qualify if their membership represents as few as 25 percent of the eligible practicing physicians in the area in which they intend to serve. This contradiction is extremely important because the brochure indicates that PSRO can proceed only with majority physician support, whereas the regulations allow for a small minority of physicians to apply for a contract.

A further omission from the brochure is the provision of the PSRO law that prior approval of hospitalization may be required with the consequent loss of freedom of choice to both physicians and patients as to their judgment of what is in the patient's best interest. This is provided in Section 1155. The brochure fails to mention the system of sanctions including fines of up to $5,000 and withholding of payment for services as provided under Section 1160.

The above and other provisions of the law have been observed to

violate Article I, Section 8 of the Constitution of the United States as well as the First, Fourth, Fifth, Seventh, and Ninth Amendments. In view of such important questions of constitutional legality, the entire brochure must be considered trivial and misleading. HEW is apparently trying to promote a dangerous and constitutionally invalid program.—**Carl Bearse, M.D., editor.** *Massachusetts Physician,* **July 1974. Reprinted with permission.**

Physicians' Reaction to Change: A Suggested Rx

CHANGE is eternal and not new, but the ever-increasing exponential rate of change makes its effect more keenly felt by the individuals of any one generation. The effects of such rapid change served as the theme for a recent best selling book. Medicine, too, is evolving through its "future shock" both with respect to technical-scientific advances and to methods for providing medical care.

He who pays the fiddler claims privilege to call the tune; and with the appearance of third parties (private and governmental) there have emerged such concepts as utilization review, prepayment, precertification, and PSRO. These concepts were virtually nonexistent 10 years ago. In this we see loss of physician and patient independence, and threat to the traditional doctor-patient relationship. Our reactions to this have been predictably varied: to comply or to resist? to do so passively or actively? Following are a few thoughts in this regard.

There is very much that is good about American medicine. There is also much that can be improved. It is important to acknowledge that some change in the health care system is the inexorable dictate of time and circumstance and not the result of a sole political or social-economic philosophy. (To think otherwise is paranoia, but to deny the existence of forces seeking to exploit this change to personal or group advantage would of course be naivete.) The often quoted "God grant me the serenity to accept the things I cannot change, courage to change the things I can, and wisdom to know the difference," could serve as an appropriate guide to physicians.

The collective wisdom of organized medicine has found it painful and difficult to arrive at unanimously agreed upon decisions in these matters. Ultimately each of us must exercise the best judgment of our own conscience with respect to our contribution to change in medical care. One fact stands out. That which doctors know best and do best is the practice of medicine. A motivation of genuine concern for patients as people and a dedication to sound principles of good medical practice provide the medical profession its true foundation of strength in its relationship to politicians, insurance carriers, hospital administrators and "consumers." It is from this point of reference that physicians derive the best and only chance of significantly influencing the shape of things to be.—**William R. Clark, Jr., M.D.,** *The Bulletin of the Fort Wayne Medical Society,* **Aug. 1974.**

Editorial Notes . . .

HEW has signed a 15-month, $114,468 contract with the American College of Physicians, the American Academy of Family Physicians, the American College of Surgeons and the Infectious Disease Society of America to develop guidelines, criteria and standards for the use of antibiotics, which can be used by PSRO's to identify cases of potentially excessive, insufficient, or inappropriate use of antibiotics.

Periodically reports arrive from England concerning therapy of constitutional disease by use of pharmaceutical products. In such cases it is usual to find that most of the "new" drugs mentioned by the Britishers as their favorites are unknown and unavailable in this country despite having been in general use for several years overseas. The latest example concerns drugs for hypertension—the English doctors have several very effective preparations that we don't have access to. Our FDA is fond of saying that we have all the drugs we need and that there is no delay in FDA approval of new drugs. One reason why foreign doctors and their patients enjoy new drugs for years before we do is that the FDA has a rule that the FDA should not pay attention to foreign drug trials. Apparently on the theory that a drug which is reliable in Europe will, of course, be unreliable over here.

The Pharmaceutical Manufacturers Association has reviewed the literature on deaths due to adverse drug reactions. The conclusion is that 3,000 or fewer deaths occur annually in the U.S. in patients with nonlethal diseases. The original report, a few years ago, was based on statistics in one hospital. Many of the patients in this series who died after a drug reaction had a fatal disease at the time—the death could not necessarily be charged to the drug. Since then the figures have been extrapolated, multiplied and exaggerated until the latest scare headline puts the total national adverse reaction toll at 140,000. The PMA seeks to set the record straight.

Metropolitan Life reports that the result of measles (rubeola) vaccine has been dramatic. Since 1963 the incidence of U.S. cases of measles has dropped from around 400,000 annually to less than 27,000. Deaths have decreased from around 400 in 1963 to none in 1972.

Research and development expenses in the pharmaceutical industry are enormous. New drugs that are successful and come to market cost their maker millions of dollars before a single prescription is sold. The expansion of the American drug makers into foreign markets has enabled them to keep prices down because they are spreading the R & D expenses over the foreign

as well as the domestic market.

The old refrain to the effect that the use of antibiotics allows the bacterial world to adjust itself and become resistant to antibiotics has come up short recently. Several long-term studies indicate now that the incidence of bacteria resistant to the common antibiotics has decreased rather than increased.

Pharmaceutical manufacturers are accused of high profits. The fact is that they make 4.7 cents profit per dollar of prescription sales. The price of prescription drugs is decreasing. Today they account for about eight cents of the medical dollar—in 1962 the figure was 16 cents.

With the widespread unnecessary and meddlesome activity of the FDA in regard to many prescription drugs it is ironic that over-the-counter drugs which are monitored by another federal agency are handled so loosely. Calomel is available in at least three nonprescription laxatives. Two cases of severe mercury poisoning were reported recently. Patients had taken the calomel regularly for years, evidently without proper precautions.

Health Insurance Institute reports that nutritionists are becoming worried about the eating habits of teenagers. The ordinary nonsystematic diets of young people are bad enough but the real chiller is the Zen Macrobiotic diet which makes brown rice the food staple while recommending the dieter give up meat and fill in with certain fruits and exotic vegetables. Six cases of death or near death were recently reported in New Jersey as a result of Zen Macrobiotic. Says one expert: "Absolute disaster."

A new VA hospital, designed to withstand a major earthquake, is being built at Loma Linda, California. Extensive studies have been completed in regard to known earthquake faults. The total cost is $53 million, construction time 2½ years. The hospital will be affiliated with Loma Linda University Medical School.

There is a new book out. Title is PILLS, PROFITS, and POLITICS. Written by Milton Silverman and Philip R. Lee on the subject of how drugs are misrepresented by their makers, misprescribed by physicians and misused by patients. The book may be judged by the authors' suggested cure for the alleged ills. That is to incorporate rational prescribing guidelines in national health insurance and if the doctor prescribes the wrong drug for the wrong patient, in the wrong amounts, and with no consideration of costs, the program would not pay for it.

Politicians are anxious to publish a new drug compendium. Senator Kennedy refers to strong support by MDs for such a publication. However, a 1968 survey by Opinion Research Corporation showed that 64% of doctors polled found existing prescribing information adequate. Only 15% thought a new compendium was needed, and only 6% felt the government should prepare it.

The AMA will participate, as amicus curiae, in a suit to declare unconstitutional a federal law requiring mandatory retirement of U.S. Civil Service employees at a particular age. The medical opinion as expressed by the AMA is that "workers who are capable and who personally desire to postpone retirement should be encouraged to do so by adoption of flexible retirement policies by both industry and government. Biological age, not chronological age, should be used in deciding when a man should retire."

"The high price of drugs" is heard often but is actually a misnomer. Since 1960 the price of drugs has decreased by 6%. The price of all items in the Consumer Price Index has risen more than 50% and the cost of health care has risen 74%. The 6% decrease is according to the Firestone Index. The Bureau of Labor Statistics shows a decline in drug prices since 1960 of 12.8%. Drugs are safer and more efficacious than ever before, but not as expensive. In fact, prescription drugs are the best bargain available.

Writing in Upjohn's "Guidelines to Metabolic Therapy," Harvey L. Levy, M.D., professor of neurology at Harvard, recommends the routine testing of a newborn's urine and blood for a variety of metabolic disorders. Now that the testing of newborns for PKU is commonplace, he suggests that such conditions as maple syrup urine disease, galactosemia, tyrosinosis and homocystinuria may be done on the same blood. There are also disorders detectable by urine test—e.g., cystinuria, Hartnup "disease," iminoglycinuria and Fanconi syndrome. Many of the listed diseases are as frequent or even more frequent than PKU.

The Pharmaceutical Manufacturers Association has prepared a critique of the FDA's study of physicians' drug information needs and problems. The PMA contends the format of the study was faulty and that it had built-in biases. Also that the questions were worded in such a fashion as to procure answers prejudiced to the philosophy of the FDA.

Reassuring phrases are appearing all over the place in an attempt to explain that PSRO will NOT breach medical confidentiality. The reason it will NOT, they say, is that there are prohibitions and penalties written in the law to maintain confidentiality. How is Congress going to enforce this when they were not able to control news leaks on a daily basis from the House Judiciary Committee? ◄



ABSTRACTS, BOOK REVIEWS

REVIEW OF MEDICAL MICROBIOLOGY

Ernest Jawetz, Joseph L. Melnick, Edward A. Adelberg, 11th ed., Lange Medical Publications, Los Altos, Calif., 1974; $8.50.

This 11th edition of *Review of Medical Microbiology* incorporates recent developments in this highly important field. The target audience is the medical student, house officer and practicing physician—certainly a comprehensive group. The text is well illustrated with black-and-white line drawings and photomicrographs. As an example of its approach to essentials, one might cite the section on "Mechanism of Action of Antimicrobial Drugs," pages 112-115. Here, the divergent methods of attack of the sulfonamides, penicillins, polymyxins, chloramphenicol, actinomycins, and so on, are clearly delineated in readily understandable language. Chapter 40, "Oncogenic Viruses," is excellent. While pointing out that a vital origin for cancer has not been demonstrated in man, "it would be illogical to suppose that the human species is unique in the animal world in escaping virus-induced malignant organisms."

The text has an adequate index, is sturdily bound in heavy plastic. Published in many languages, the cost of $8.50 makes it, like so many other texts of Lange Medical Publications, a real bargain in these days of sky-high costs of medical books.

W. D. SNIVELY, JR., M.D.
Evansville

DORLAND'S ILLUSTRATED MEDICAL DICTIONARY

Twenty-fifth edition, W.B. Saunders Co., Philadelphia, 1974; John P. Friel, editor; 1748 pages; standard ed. $21.00, deluxe $28.50.

This anniversary edition has had the benefit of some fourscore consultants who aided in bringing the definitions *really* up to date! Just last year (*JISMA*, July 1973) I had the pleasure of reviewing another updated dictionary. This one is even more lavishly accoutered, glitters almost gaudily and hefts a substantial six pounds.

"By coding individual entries according to discipline," the editors reviewed *all* entries and so were able to update, discard, label as obsolete or otherwise emend each and every entry of previous editions! As the editors remark, "codification of knowledge is made increasingly difficult by the steadily widening scope and mounting complexity of contemporary medical science." "The function of a dictionary must be something more than that of usage . . . . Certain standards of etymological propriety and of selection are also a responsibility of the lexicographer—no less in the language of science than in that of imaginative or creative writing." One can only say, Amen! to this.

At the quoted prices, this dictionary is more than reasonable. It deserves the widest dissemination!

ARNOLD LIEBERMAN, M.D.
New York City

STRESS WITHOUT DISTRESS

Hans Selye, J. B. Lippincott Co., Philadelphia, 1974; $6.95.

Hans Selye has done it again! Primarily a basic scientist, Dr. Selye has remarkable talent for expressing his concepts in simple, interesting terms. *Stress Without Distress* is a logical development from and sequel to Selye's great book for the laity, *The Stress of Life*. In *Stress Without Distress,* Selye summarizes his theories concerning the role of stress and points out that while stress is indeed the spice of life, it can be destructive, causing a cluster of ailments ranging from ulcer to heart disease.

Even in Selye's earlier writings, he has emphasized the importance of service to one's fellow man and the gratitude that often (but not always) results from such service. In this book, Selye expands somewhat on his humanistic philosophy. He enlarges upon the concept of work as rewarding and joyful play. He describes the relationships between work, stress, and aging. His prescription for enjoying a full life lays out in practical terms how one can capitalize on stress without being destroyed by it. In a broad sense, he is endorsing the application of the golden rule. He states that no one will be disappointed if in daily life he follows the guiding light of "earn thy neighbor's love." One gets the picture throughout the book not only of a great scientist who can express himself lucidly, but of a thoroughly good person—and, incidentally, a great man. This book can be wholeheartedly recommended for members of the profession and laity alike. It is bound in hard cover and sells for $6.95.

W. D. SNIVELY, JR., M.D.
Evansville

THE ULTIMATE STRANGER, THE AUTISTIC CHILD

Carl H. Delacato, Doubleday & Co., Garden City, N.Y., 1974; $6.95.

In *The Ultimate Stranger, The Autistic Child,* Delacato has presented a striking and shocking account. He tells of the strange children endlessly biting their own members, banging their heads against walls, splitting open their heads on the doctor's desk, vomiting on his new rug. These lonely aliens, he points out, have been institutionalized for life, presumably because we frighten them but really because they frighten us. And so, in this book he takes the reader on a personal journey into the strange world of the autistic child.

Autistic children have been with us a long time; they are not a recent development. Their treatment throughout the ages constitutes a saga of unbridled cruelty. In studying many of these children, Dr. Delacato, Associate Director for the Institutes for the Achievement of Human Potential, arrived at some startling conclusions: "These children were not psychotic. They were brain injured and had severe sensory problems. They could not deal with the stimulation coming into their brains from the outside world. . . . Their strange repetitive behavior was their attempt, through much repetitive stimulation, to normalize" their intake channels of sight, sound, taste, smell or feel. In short, concluded the author, they were not autistic for psychological reasons; they were brain injured, behaving as they did for neurological reasons.

With the aid of numerous case histories, Dr. Delacato tells how he developed and put his theory into practice, in some instances achieving relative success and others not being able to break the barrier that would free these ultimate strangers from their internal prisons created by sensory disturbances.

The book, which is bound in hard cover and sells for $6.95, is recommended for all physicians who will be in a position to see autistic children.

W. D. SNIVELY, JR., M.D.
Evansville

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SELECTIVE INHIBITORS OF VIRAL FUNCTIONS

W. A. Carter, with 24 co-authors, Chemical Rubber Co., Cleveland, 1973; 377 pages; $39.95; with some illustrations, tables, charts and an exhaustive list of references after each article.

This is a well crafted volume, modest in appearance and rather smallish for what it aims to do: to provide in briefest possible space the present day knowledge—ALL knowledge—pertinent to its stated topic with an exhaustive list of all conceivable references. It all but succeeds in being the smallest "Handbuch" I've ever had the privilege of perusing. The rather hefty price begins to seem not out of bounds when the amount of summarized information is perused.

Thus (p. 69) I learn that the sheep disease, "scrapie," is indistinguishable from the same Visna viruses that cause in humans such diseases as multiple sclerosis! Further: actinomycin D, when given early enough in the progression of the ailments *may* be curative. The discussion on the "oncogene" that follows is most instructive and almost all news—at least to me!

The exhaustive discussion on interferon starts out by telling us that its production can be induced but only in vivo in such micro-organisms as bacteria, protozoa, rickettsiae and in gram-negative (*not* gram-positive) strains! How come? And then (p. 208) we learn that Amantadine can be produced against influenza A but not B! The analysis of the stereo-isomeric organic chemical reasons for this is truly skirting the very frontiers of our knowledge as of today, but then someday we can hope for a simplification and greater use of the knowledge so obtained. We could go into endless detail anent the antiviral properties of the streptovaricins and many other recondite phenomena, e.g., an inhibitor of the given polymerase will stop replication of the virion. This is difficult (I do believe, for the Professor of Biochemistry, but then the next generation will be learning!)

ARNOLD LIEBERMAN, M.D.
New York City

CONFERENCE ON CARDIOGENIC SHOCK: PRESERVATION OF ISCHEMIC MYOCARDIUM

New York Heart Association Bulletin, reprinted from "Bulletin of the N.Y. Academy of Medicine," Second Series, Vol. 50, #3, 243-390, March 1974.

Having had the good fortune to have just reviewed Braunwald's tome, "The Myocardium: Failure & Infarction," as well as Willis Hurst's "The Heart," it would be almost a supererogation to go into lengthy encomiums on this bit of a gem of clear, lucid and simple discussion on the topic just as stated.

It should suffice to say that the average M.D. or even a senior medical student can get a quick overlook of the topic. The diagrams, tables and photographs are just to the point. The paper and printing are excellent. These paperback reprints are easily obtained for a mere pittance.

Try scanning it; you may even agree with me.

ARNOLD LIEBERMAN, M.D.
New York City

ADVANCES IN BIOPHYSICS—VOL. 5

Masao Kotani, editor, University of Tokyo Press, University Park Press, Baltimore; 1973; 210 pages with numerous tables, figures and illustrations; $14.50.

As a rule, the Japanese are superb in their meticulous analyses and crisply deduced conclusions. Having been so tremendously impressed by their symposium on "Muscle Proteins, Muscle Contraction and Cation Transport" (*JISMA*, Dec. 1973, 1110), I was looking forward eagerly to this slim but superbly accoutered volume. Well, I must have been expecting the impossible. The entire subject is still in a state of flux and no really teaching news seemed to emerge from this little monograph.

The subject matter is divided into the appropriate chapters. Thus: "Regulatory Mechanisms in the Sex Cycle," "Central Mechanism of Feeding," "Contractile Proteins from the Myxomycete Plamodium," "Assembly of Myosin Molecules into the Structure of Thick Filaments of Muscle," and—finally—a crisp summary.

Well! At least as far as I'm concerned, I'll await the next symposium when more firm (and newer) data will—hopefully—be available. As usual, the paper, binding and printing are up to the highest possible standards.

ARNOLD LIEBERMAN, M.D.
New York City

ESSENTIALS OF CARDIAC ARRHYTHMIAS: DIAGNOSIS AND MANAGEMENT

Samuel Bellet, M.D., W.B. Saunders Company, Philadelphia, 1973; 458 pages; 237 illustrations; $15.50.

By a tragic twist of fate, Professor Bellet completed his final revisions of this monograph just *hours* before his sudden collapse and death. In a very true sense, this monograph is his legacy to succeeding medical generations.

I had read his third edition of *Clinical Disorders of the Heart Beat;* in a very real sense I had been prepared for the material found here. The volume is precise, concise and uses language suitable for the medical student *and* the chairman of the department: a pedagogical feat of no mean dimensions. The chapter heads are clear; the profuse E.K.G.s illustrate the points being expounded in the text.

This volume will sit on my working shelf. When a diagnostic point may seem to confuse: take this book down and find the answer: I enjoyed the Glossary thoroughly! The definitions are simple and to the point. Even words like "Accrochage" (Do you know its meaning?) are pithily delineated. Also, I would recommend highly Chapters 32, 33, and 34, where the precise uses of the various groups of cardiac drugs are presented in splendid pedagogical fashion. All in all, it will be a *very* long time before this volume will become outdated! Congratulations to all those who saw to it that this volume was published!

ARNOLD LIEBERMAN, M.D.
New York City

MALIGNANT DISEASES OF THE HEMATOPOIETIC SYSTEM

Japanese Cancer Association, Gann Monograph #15, edited by Kaneyoshi Akazaki and associates, University Park Press. Baltimore, 1973; $32.50, beautifully illustrated; 320 pages.

This is a very intriguing monograph in which the participants discuss in profunda, a topic that is only now coming into greater and greater focus. Even the presumed expert can learn much by a careful perusal of these pages. A careful scanning of the electron microscopic illustrations adds much to the text.

I confess to being puzzled by several items. Thus: on page 5 I read the word, "Tingible." As it is repeated over and over again, this cannot be a mere misprint. Yet the word is in no dictionary available to me and it truly obfuscates (at least to me) the message I am supposed to be getting. Also, the photos are not numbered and I'm supposed to count from the start to

get the photo being analyzed: That does *not* make for easy reading.

On page 71, I was instructed by reading about the RETICULOSARCOMA and the RETICULOENDOTHELIOMA. This chapter alone is worth the price of this book. And then from page 217 on, Professor Karl Lennert gives a most incisive discussion of "Follicular Lymphoma"—well worth repeated perusal! And further: from page 305 on, my namesake, Philip H. Lieberman with his associates, presents in depth the "Further Thoughts on the Eosinophilic Granuloma Problem." Its separation of the benign and malignant was news to me; this may be true for you also!

All in all, this is a first class monograph that belongs not only on the shelves of hematologists, hospital and medical school libraries but may even be acquired with accumulating profit by the internist. All M.D.'s would do well to peruse this even if only occasionally.

ARNOLD LIEBERMAN, M.D.
New York City

Abstracts from Various Literature, Prepared by AMA

DOUBLE RENAL TRANSPLANTS FROM PEDIATRIC DONORS TO ADULT RECIPIENTS

D. W. Kinne et al. (R. L. Simmons, Univ. of Minnesota Hospitals, Minneapolis 55455)
Am. J. Surg. 127:292-295 (March) 1974.

Ten pairs of kidneys from pediatric cadaver donors were transplanted in patients with renal failure. Preservation by perfusion and transplantation are carried out by way of the distal aorta after the proximal aorta and vena cava are closed. Seven of the ten pairs of kidneys have normal function 16 to 24 months later. Since pediatric donors appear to be unusually frequent, this technique permits transplantation of pediatric kidneys into adults and provides adequate renal mass for normal function.

RECENT ADVANCES IN TREATMENT OF EWING SARCOMA

S. Seeber el al. (55 Hufelandstrasse, Essen, West Germany)
Dtsch. Med. Wochenschr. 99:883-887 (April 26) 1974.

The prognosis of Ewing sarcoma is still very bad, although the tumor is highly radiosensitive. Five-year survival rates between 10% and 15% have been reported. Three cases of metastasizing Ewing tumor are described, all of them with advanced pulmonary disease. Combined chemotherapy with adriamycin, cyclophosphamide and vincristin, in addition to local radiotherapy, brought about complete remission in two and partial remission in the third patient, with disappearance of the pulmonary metastases in all three.

BETA-BLOCKADE AND PARTIAL THYROIDECTOMY FOR THYROTOXICOSIS

W. Michie et al. (Aberdeen Royal Infirmary, Aberdeen, Scotland)
Lancet 1:1009-1011 (May 25) 1974.

A group of thyrotoxic patients prepared for surgery with conventional antithyroid drugs is compared with similar groups pretreated with the beta-adrenoceptor blocker propranolol with and without Lugol iodine. Several differences in biochemical behavior, both preoperatively and after operation, were observed. No adverse results from propranolol therapy have been encountered.

RADIOIMMUNOASSAY OF CARCINOEMBRYONIC ANTIGEN

F. W. Nugent (605 Commonwealth Ave., Boston 02215) and E. R. Hansen
Arch. Intern. Med. 134:59-61 (July) 1974.

Results of a radioimmunoassay of carcinoembryonic antigen as a diagnostic test for carcinoma of the colon and pancreas are reported. Blood samples were drawn from 162 patients—75 with known or suspected carcinoma of the colon or pancreas, 10 with other gastrointestinal malignant neoplasms, 7 with nongastrointestinal malignant neoplasms, 32 with a variety of nonmalignant gastrointestinal diseases, and 38 with no significant disease. The assay was not found to be specific for carcinoma of the colon or pancreas and a significant level of false-positive tests was encountered.

DETERGENT INGESTION: UNIQUE EXPERIENCE OF FAMILY

M. M. Berenson (Univ. of Utah Medical Center, 50 N. Medical Dr., Salt Lake City 84112) and A. R. Temple
Clin. Toxicol. 7:25-28 (No. 1) 1974.

A 13-year-old white boy was seen by a pediatrician because of a pharyngeal ulcer. During a birthday party three days earlier, a youth apparently played a prank on the patient and his family by adding Woolite powder to the sugar bowl. Woolite is considered a cold-water soap. The granular form is composed of anhydrous soap 16%, sodium tripolyphosphate 60%, and synthetic detergents (mainly lauryl sulfate) 24%. Its pH is 7.0 to 8.5 depending upon dilution. Following the birthday party, the family ate supper with the sugar-Woolite mixture. The family experienced nausea, vomiting, and then diarrhea. All family members experienced discomfort on swal-

Continued



lowing and the parents particularly complained of "heartburn." The mother was found to have a few superficial erosions of the distal esophagus and gastritis. The son and one daughter had small pharyngeal burns. Barium swallow was performed approximately one month later on the father, mother, and son; no strictures were found.

OPERATIVE CHOLANGIOGRAPHY IN RURAL SURGICAL PRACTICE

C. A. Wiethoff et al. (Marion County General Hosp., Indianapolis 46202)

Arch. Surg. 109:254-256 (Aug.) 1974.

Operative cholangiography was routinely performed during 826 cholecystectomies carried out by one physician in a private surgical practice in rural Indiana between January 1962 and January 1973. The technique of cholangiography, which involves two injections into the gallbladder neck, avoids cystic duct cannulation and adds no more than five minutes to the operating time. Satistical data were derived from the records of 547 patients observed from one to ten years. Choledochotomy was done in 127 patients, yielding stones in 103 and other lesions in 19. Explorations based on abnormal roentgenographic findings yielded no stones in five patients (4% of explorations and 0.9% of roentgenograms), and stones were found in the ducts of two patients in spite of normal roentgenograms (2% and 0.4%). Totally unsuspected stones were found in nine patients (representing 7% of the duct explorations). These data are similar to those reported by others.

ANESTHETIC PATCH FOR PAINFUL PROCEDURES SUCH AS MINOR OPERATIONS

H. M. Lubens et al. (310-320 Harries Bldg., Dayton, OH 45402)

Am. J. Dis. Child. 128:192-194 (Aug.) 1974.

The anesthetic patch with 30% lidocaine cream, applied occlusively to an intact skin area for a period of time, produces complete, demarcated, localized skin anesthesia. The anesthetic patch was utilized for minor surgery, spinal taps, venipunctures, intradermal allergen testing, and other painful procedures such as bone marrow punctures. In a series of over 10,000 patient-uses in clinic and office practice, effectiveness and absence of adverse reaction were demonstrated. Use of the anesthetic patch should promote better acceptance of diagnostic and therapeutic procedures, especially in apprehensive children and adults.

MALIGNANT TUMOR FOLLOWING RENAL TRANSPLANTATION

W. Wegmann et al. (Pathologisches Institut des Kantonspitals, Rheinstrasse 37, Liestal, Switzerland)

Schweiz. Med. Wochenschr. 104:809-814 (June 8) 1974.

Five of 139 patients who survived for more than four months following kidney transplantation suffered malignant lymphoma (three cases) or carcinoma of the bladder (two cases). The tumor incidence was about 3%. In each case the malignant lymphoma was classified as a reticulosarcoma. Diffuse tumor involvement was found in one patient and was diagnosed only at autopsy. The brain and transplant were involved in a second patient, and the brain alone in a third. Immunosuppressive therapy was continued in all patients.

INDICATIONS FOR EARLY HEMODIALYSIS IN MULTIPLE TRAUMA

H. Champion et al. (Univ. of Maryland Hosp., Baltimore 21201)

Lancet 1:1125-1127 (June 8) 1974.

Renal function in 751 cases of multiple trauma was studied to define a level of function compatible with ultimate survival. A daily renal index was calculated using urine volume, serum creatinine, and blood urea nitrogen (BUN). Probability of survival was less than 0.1 in patients with a creatinine>4 mg/100 ml or a BUN>80 mg/100 ml or a renal index >3 on one occasion or >2 on two consecutive days. The renal index provided an earlier and more accurate prognosis in a significant number of patients when compared with the other variables. Dialysis to within the levels shown to be compatible with survival offers a method of reducing the high mortality in patients with multiple trauma and probable renal failure.

About Our Cover

LeBien Hall at Valparaiso University houses Indiana's newest College of Nursing. Its first class was graduated in 1972. Adjacent to Porter Memorial Hospital on the edge of the University campus, it is tied in with the state's medical closed circuit color television network and is professionally accredited by the National League for Nursing. Dean Dorothy Smith is secretary of the Indiana State Board of Nurses' Registration and Nursing Education.

Founded in 1859 by citizens of Valparaiso, Indiana, Valparaiso University has been operated since 1925 by the Lutheran University Association, soon to celebrate its 50th anniversary. It is the nation's largest Lutheran university with an annual enrollment of more than 5,000 students. Dr. Albert G. Huegli became its 15th president in 1968. Its beautiful Chapel of the Resurrection, one of the world's largest campus worship centers, is an architectural landmark.

The College of Nursing is one of eight principal academic units offering 60 fields of study leading to 17 degrees and hundreds of career opportunities. Other undergraduate colleges are Arts and Sciences, Business Administration, Engineering, and Christ College—an honors program. Valparaiso University also has a Graduate Division and a School of Law—one of four in the state. In addition, the Continuing Education program offers evening, extension, and summer courses and institutes.

FUTURE MEETINGS, SEMINARS, COURSES

Schedule Gastroenterology Course

A postgraduate course in gastroenterology will be conducted by the American College of Gastroenterology on October 24 to 26, at the Americana in Bal Harbour, Florida, just following the Annual Convention of the College. For more information write the College at 299 Broadway, New York City 10007.

Industrial Medical Meeting in Iowa

The Central States Society of Industrial Medicine and Surgery will meet on Oct. 25 and 26 at the University of Iowa Medical School, Iowa City. For a copy of the program write Rita Parker, in care of the Society, 150 N. Wacker Drive, Chicago 60606.

Program on ER Care at New Orleans

A two-week course on "Emergency Room Medical-Surgical Care" will be conducted at the Ochsner Medical Center in New Orleans from November 11 to 23. Registration is limited to 14. The fee is $400. Write the Division of Education, Alton Ochsner Medical Foundation, 1514 Jefferson Highway, New Orleans 70121.

Family Practice Program Offered

The Institute for Continuing Education is conducting a program for family practice to be monitored by the University of Maryland School of Medicine and the University of Puerto Rico School of Medicine at San Juan, Puerto Rico, November 20 to 24. Planes leave Baltimore, New York or Chicago. For all inclusive fare schedule write the Institute at PO Box 11083, Richmond, Va. 23230.

More Courses Announced by IUSM

The Division of Postgraduate and Continuing Medical Education, Indiana University School of Medicine, has announced the following courses to be held in December and January:

"Current Pediatric Management—A New and Individualized Teaching Course"—Dec. 4, 1974

It will provide an opportunity for the participants to elect up to 8 topics from at least 12 offerings from such areas of pediatric interest as gastroenterology, cardiology, endocrinology, infectious disease, child development, emotional disorders, neurology, pediatric surgery, hematology, oncology, dermatology and ambulatory care. Each of the topics will be covered in a small group with, hopefully, no more than eight participants for each instructor. In addition to a general presentation, there will be full opportunity for interchange between the instructor and the participants. Clinical cases will be utilized whenever possible.

"Kidney Disease"—Dec. 5, 1974—Reid Memorial Hospital, Richmond

The practical aspects of understanding and managing the most common renal disorders encountered by the clinician in practice will be discussed by men who are experts in their various fields. In particular, there will be an attempt to give guidelines for recognizing that small segment of patients with kidney disease who can be treated only in the larger medical centers.

"Current Concepts in Cancer Chemotherapy and Immunotherapy" Jan. 15, 1974

This course is primarily designed for family practice physicians, internists and any physician involved in the treatment of the patient with disseminated cancer. The course will emphasize basic concepts in cancer chemotherapy and also discuss approaches involving combination chemotherapy utilizing the newer and investigational cancer chemotherapeutic agents. The role of immunotherapy for neoplastic disease will also be discussed.

For further information contact: Division of Postgraduate Medical Education, Indiana University School of Medicine, 1100 West Michigan St., Indianapolis 46202.

Gastrointestinal Emergencies Subject Of December Symposium at Hahnemann

Hahnemann Medical College will conduct a 3-day symposium on "Gastrointestinal Emergencies" December 2 to 4 at Marriott Motor Hotel in Philadelphia. The course is accredited for postgraduate credit by AMA, AAFP and ACGP. Fees are $200 for practicing physicians (lunches included) and $50 for House Staff Officers and Fellows (lunches not included). For more details write Division of Continuing Education, Hahnemann Medical College, 230 N. Broad St., Philadelphia 19102.

Laryngology-Bronchoesophagology and Neurotology Courses to Be Conducted

The Department of Otolaryngology, Abraham Lincoln School of Medicine, and the University of Illinois Hospital Eye and Ear Infirmary have announced the following continuing education courses:

March 17-25, 1975—Laryngology and Bronchoesophagology. The course is limited to 20 physicians and will be under the direction of Paul H. Holinger, M.D. It will be held largely at the Eye and Ear Infirmary, 1855 West Taylor Street, Chicago, and will include visits to a number of other Chicago hospitals. Instruction will be provided by means of animal demonstrations and practice in bronchoscopy and esophagoscopy, diagnostic and surgical clinics, as well as didactic lectures.

March 24-27, 1975—Neurotology. This four-day intensive course will offer a didactic and practical review of clinical neurotology under the direction of Nicholas Torok, M.D. It will be held at the Eye and Ear Infirmary and will include basic vestibular physiology and pathophysiology, commonly used testing methods applied in functional examination of the vestibular organ.

In addition, various forms of caloric testing procedures will be demonstrated using nystagmography, reading and evaluation of the test results, particularly the nystagmogram, and correlation with audiometric and neurologic findings, final neurotological diagnosis, management and treatment. Patients will be tested by participants, and the history, symptoms and test results will be discussed in informal conferences.

Enrollment is limited to 15. For application forms write to the Department of Otolaryngology, 1855 West Taylor Street, Chicago 60612. ◄

The Woman's Auxiliary Reports to ISMA

Dear Doctor:

The following is something the National President of the Medical Auxiliary, Betty Liljestrand, has told the members and I feel it is of particular interest to our physician husbands.



"I travel with a briefcase in one hand and a typewriter in the other. This prompts seatmates to ask what I do. I used to explain that I work for the Women's Auxiliary to the AMA. Every single time, I drew a blank. Not once had anyone heard of us. So now I go step by step.

"First I say I work for a service organization. Then I mention 90,000 members. Then I say I help to coordinate extensive volunteer projects, and I mention a few. Then I explain that all this is carried on by doctors' wives of America. It then has meaning. . . ."

Her statements set me to thinking—this year we passed the 90,000 mark in membership. Imagine! Together we make up an organization of massive potential—90,000—a figure almost too great to visualize. If we were to walk through a door, one at a time, each minute of a working day, it would take nine months for all to pass. Think of the resulting power—and this is on the national level.

Here in Indiana we have 2,700 members and it would take our members 5½ working days to pass in review. We could do much better than that if each of you would make an effort to encourage your wife to become a member of the Auxiliary. Yes—I have stressed membership in a previous article but I think very strongly it is a subject that needs repeating.

We are most anxious to be of help to you in furthering Medical Education and Research, Political Action, Health Education, Immunization and the many other medical aspects of this modern age; but to help you, we need your and your wife's involvement.

Warmly,

Beth Bowen

President, Woman's Auxiliary, ISMA



TAX TIPS

by LAWRENCE A. JEGEN, III

Mr. Jegen is a professor of law at Indiana University Indianapolis Law School, specializing in taxation, business associations and estate planning. Professor Jegen urges the reader to consult the reader's lawyer before applying the data in this article to a particular fact situation.

This article is the third article in a series which concerns the estate planning possibilities which are available with private annuities. The first two articles of the series appeared last month and the month before, and the reader might want to read (or re-read) those articles prior to reading this one, because I intend to refer to the illustration of the private annuity which is presented in those articles.

Briefly, the example involved a sale of land by a father to his son, which land had a fair market value of $60,000, an adjusted basis to the father of $20,000, and for which the son was to pay the father $7,200 per year for the remainder of the father's life, which was estimated to be 10.1 years. The present value of the son's promise to pay the annuity (per the 6% annuity tables in the Treasury's Regulations) was $42,749.

Thus, the father made a taxable gift of $17,251 ($60,000 − $42,749) to the son.

Further, the father excluded, for income tax purposes, 27.5% of each $7,200 payment, namely, $1,980, as return of his adjusted basis. The 27.5% was determined by dividing $20,000 by $72,720 ($7,200 x 10.1).

Further, the father had to report, for income tax purposes, $22,749 ($42,749 − $20,000) of long-term capital gain over 10.1 years, namely, $2,252 per year.

In addition, the father had to report each year, for income tax purposes, ordinary income of $2,968 ($7,200 minus $1,980 and minus $2,252).

Finally, after 10.1 years, the father had to report each year, for income tax purposes, ordinary income of $5,220 ($7,200 − $1,980).

Now for some additional observations.

If the child purchases (from the parent) property which the child intends to depreciate, then the child must determine, at once, the basis of the property, to the child, for depreciation. And, under Rev. Rul. 55-119, the general rule is that the child's basis for depreciation is equal to the actuarial value of the child's annuity promise at the date on which the sale agreement is executed. The actuarial value of the promise is determined by using the actuarial tables which are published in both the gift and estate tax regulations. See U.S. Treas. Regs. §25.2512-5. When the principal payments, which are made by the child to the parent for the purchase of the property, exceed the initial actuarial determination of the child's promise to make the payments, then each additional principal payment is added to the child's adjusted basis for the property. Then, the child is entitled to depreciate each additional payment under the normal rules which are applicable to the depreciation of real estate. Obviously, when the father dies, the child's obligation to continue the annuity payments ceases. Therefore, at the father's death, the child's adjusted basis for the property is merely the adjusted basis which is determined under rules which I have briefly described.

In one sense, the child is bound to have mixed feelings (tax-wise, that is) about the parent's health. If the parent dies soon after the sale agreement is executed, then the child may have paid very little money in order to acquire very valuable property. However, the child's adjusted basis for the property may be much lower than the amount which would have been the child's adjusted basis for the property—had the parent transferred the property to the child at the parent's death. In the latter event, the child's adjusted basis for the property would have been the fair market value of the property at the parent's death. On the other hand, as I stated earlier, if the parent has a long life, then the child may pay considerably more for the property than the child anticipated paying, and/or more than the child can afford and/or more than the value which the child would have received upon the death of the parent. Of course, in such a case, the child may, as a result, have an adjusted basis for the property which greatly exceeds the "death value" basis which the child might have been able to use—had the parent transferred the property to the child at the parent's death.

If the transaction between the parent and the child results in some of the value of the property as being treated as a gift from the parent to the child, then you might not be able to accurately compute the child's total adjusted basis for the property, because the rules for determining the basis, in such a situation, are not settled. Thus, rather than presenting the possibilities which are available, I recommend that you request a ruling from the Internal Revenue Service in order to eliminate unnecessary controversy.

When you plan a sale of property in return for an annuity, be certain that you do not retain a security interest in the property or you may have the property included in your gross estate for federal estate tax purposes.

In summary, the annuity arrangement is an excellent device to transfer property (securities, real estate, etc.) during a parent's life in order to avoid estate taxes, yet to provide the parent with income until the

parent's death. The parent has the enjoyment of seeing the property, e.g., a corporation or a farm, being managed by and owned by the child during the parent's life—yet the parent continues to derive income from the property. By using the Internal Revenue Service's present actuary tables, both the parent and the child can reasonably predict the total economic impact of the arrangement upon both the parent and the child. Finally, and perhaps most important, the arrangement allows a parent to transfer certain property to one child (who wants it and who will involve himself in the operation or development of the property) and still be fair to another child, because the former child will be obligated to pay for the property and to reasonably assure that the latter child will receive a fair share of the parent's estate. ◄

INDIANA STATE BOARD OF HEALTH

MONTHLY REPORT — August 1974

Disease	Aug. 1974	July 1974	June 1974	Aug. 1973	Aug. 1972
Animal Bites	1251	1108	1637	1165	1263
Chickenpox	69	73	389	22	57
Conjunctivitis	173	187	251	190	176
Diphtheria	0	0	0	0	0
Dysentery, Unspecified	117	79	86	72	18
Gonorrhea	1838	956	1532	1250	907
Impetigo	182	188	157	227	174
Infectious Hepatitis	73	58	76	65	39
Infectious Mononucleosis	52	36	42	45	40
Influenza	2933	2345	2214	1211	1138
Measles					
Rubeola	14	10	31	7	16
Rubella	49	26	65	12	33
Meningococcic Menigitis	3	1	0	0	0
Meningitis, Other	7	2	3	2	1
Mumps	34	46	142	34	35
Pertussis (Whooping Cough)	10	4	6	3	60
Pneumonia	515	270	509	257	205
Poliomyelitis	0	0	0	0	0
Streptococcal Infections	1175	897	1583	655	672
Syphilis					
Primary & Secondary	29	10	9	22	48
All Other Syphilis	122	76	144	116	83
Tinea Capitis	7	12	12	7	6
Tuberculosis (Active)	74	28	91	45	53

Maybe the patient's self-diagnosis is right. He could have hay fever. But that bright red nasal mucosa, along with the thick discharge and excoriation around the nares, strongly suggests that the main problem is a cold. Hay fever or another form of allergic rhinitis may or may not be an underlying factor.

If a complete history and examination rule out allergic rhinitis, the long-term outlook will be a lot more favorable than his own "diagnosis" would have indicated.

But right now, whether he's got allergic rhinitis or a cold, he's suffering from the same irritating symptoms of drip, congestion and stuffiness. Try DIMETAPP EXTENTABS®. They're formulated to relieve these symptoms without much chance of causing drowsiness or overstimulation. Your patients will appreciate the 24-hour relief they can get from just one tablet every 12 hours.

Cold or



Allergy?

Whether it's a cold or an allergy, Dimetapp Extentabs® effectively relieve stuffiness, drip and congestion.

INDICATIONS: Dimetapp Extentabs are indicated for symptomatic relief of allergic manifestations of upper respiratory illnesses, such as the common cold, seasonal allergies, sinusitis, rhinitis, conjunctivitis and otitis. In these cases it quickly reduces inflammatory edema, nasal congestion and excessive upper respiratory secretions, thereby affording relief from nasal stuffiness and postnasal drip.
CONTRAINDICATIONS: Hypersensitivity to antihistamines of the same chemical class. Dimetapp Extentabs are contraindicated during pregnancy and in children under 12 years of age. Because of its drying and thickening effect on the lower respiratory secretions, Dimetapp is not recommended in the treatment of bronchial asthma. Also, Dimetapp Extentabs are contraindicated in concurrent MAO inhibitor therapy.
WARNINGS: *Use in children:* In infants and children particularly, antihistamines in overdosage may produce convulsions and death.
PRECAUTIONS: Administer with care to patients with cardiac or peripheral vascular diseases or hypertension. Until the patient's response has been determined, he should be cautioned against engaging in operations requiring alertness such as driving an automobile, operating machinery, etc. Patients receiving antihistamines should be warned against possible additive effects with CNS depressants such as alcohol, hypnotics, sedatives, tranquilizers, etc.
ADVERSE REACTIONS: Adverse reactions to Dimetapp Extentabs may include hypersensitivity reactions such as rash, urticaria, leukopenia, agranulocytosis, and thrombocytopenia; drowsiness, lassitude, giddiness, dryness of the mucous membranes, tightness of the chest, thickening of bronchial secretions, urinary frequency and dysuria, palpitation, hypotension/hypertension, headache, faintness, dizziness, tinnitus, incoordination, visual disturbances, mydriasis, CNS-depressant and (less often) stimulant effect, anorexia, nausea, vomiting, diarrhea, constipation, and epigastric distress
HOW SUPPLIED: Light blue Extentabs in bottles of 100 and 500.

Dimetapp Extentabs®

Dimetane® (brompheniramine maleate), 12 mg.; phenylephrine HCl, 15 mg.; phenylpropanolamine HCl, 15 mg.

A-H-ROBINS

A. H. Robins Company, Richmond, Va. 23220

when pain goes on... and on... and on–



For the patient with a terminal illness, PAIN past, present, and future can dominate his thoughts until it becomes almost an obsession. The more he is aware of the pain he is now experiencing, the more difficult it is to erase his memory of yesterday's pain, and to allay his fearful anticipation of tomorrow's pain.

Surely the last thing this patient needs is an analgesic containing caffeine to stimulate the senses and heighten pain awareness. A far more logical choice is Phenaphen with Codeine. The sensible formula provides ¼ grain of phenobarbital to take the nervous "edge" off, so the rest of the formula can help control the pain more effectively. Don't you agree, Doctor, that psychic distress is an important factor in most of your terminal and long-term convalescent patients?

the analgesic formula that calms instead of caffeinates

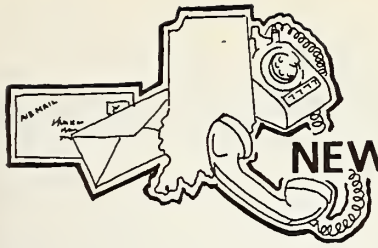
Phenaphen® with Codeine

Phenaphen with Codeine No. 2, 3, or 4 contains: Phenobarbital (¼ gr.), 16.2 mg. (warning: may be habit forming); Aspirin (2½ gr.), 162.0 mg.; Phenacetin (3 gr.), 194.0 mg.; Codeine phosphate, ¼ gr. (No. 2), ½ gr. (No. 3) or 1 gr. (No. 4) (warning: may be habit forming)

Indications: Provides relief in severer grades of pain, on low codeine dosage, with minimal possibility of side effects. Its use frequently makes unnecessary the use of addicting narcotics. **Contraindications:** Hypersensitivity to any of the components. **Precautions:** As with all phenacetin-containing products, excessive or prolonged use should be avoided. **Side effects:** Side effects are uncommon, although nausea, constipation and drowsiness may occur. **Dosage:** Phenaphen No. 2 and No. 3—1 or 2 capsules every 3 to 4 hours as needed; Phenaphen No. 4—1 capsule every 3 to 4 hours as needed. For further details see product literature.

(III) Phenaphen with Codeine is now classified in Schedule III, Controlled Substances Act of 1970. Available on written or oral prescription and may be refilled 5 times within 6 months, unless restricted by state law.

A. H. Robins Company, Richmond, Va. A·H·ROBINS



NEWS NOTES

40-MEV Linear Accelerator Delivered To I.U. Medical Center; Lions' Gift

Hoosier Lions Clubs and Indiana University School of Medicine celebrated July 29 as D-Day for the new 40-Million Electron Volt Linear Accelerator which the Lions have given to the Medical Center. The accelerator was built in France and was delivered to the Indianapolis campus. It is now being assembled in a special underground chamber beside the University Hospital. It is 40 times more powerful than existing Cobalt machines. The Lions Clubs of Indiana to date have been responsible for raising more than one and a quarter million dollars for cancer treatment equipment at the Medical Center. Now the Lions are working on an additional $140,000 for an instrument which will make the accelerator more adaptable.

Speaks on Huntington's Disease

Dr. Daniel T. Ramker, Hammond, was a guest speaker at a benefit dinner given recently by the Northwest Indiana Chapter, Committee to Combat Huntington's Disease.

White House Fellowships Offered

Each year 15 to 20 persons 23 to 36 years old are selected as White House Fellows. For one year, each one serves as a special assistant to a Cabinet Secretary or a member of the White House staff. Applicants are sought from the medical field. Applications must be postmarked no later than December 2, 1974. For further information write: President's Commission on White House Fellows, Washington, D.C. 20415, or call (202) 382-4661.

Dr. Bondurant Gets New Post

Dr. Stuart Bondurant recently was appointed executive vice-president and dean of Albany (N.Y.) Medical College. Dr. Bondurant, who is professor and chairman of the department of medicine at the Medical College and physician-in-chief of Albany Medical Center Hospital, earlier served as professor of medicine at Indiana University School of Medicine and as chief of the medical branch of the Artificial Heart-Myocardial Infarction Program at the National Heart Institute.

Fire Protection Booklets Available

"Tentative Standard on Fire Protection for Laboratories Using Chemicals" is a 52-page booklet issued by the National Fire Protection Association at a price of $2.50 per copy.

Another recent publication is "Manual on Fire Hazards in Oxygen-Enriched Atmospheres," available at $4 per copy.

Additional recent publications are: "Standards for Fire Doors and Windows," a 102-page book selling at $3.75; "Standards for Nonflammable Medical Gas Systems," a 28-page booklet which sells for $2.50, and "Standard for Bulk Oxygen Systems at Consumer Sites," a 12-page pamphlet for $2.00.

The address is 470 Atlantic Ave., Boston, MA 02210.

Dr. Frankhouser Appointed

The appointment of **Dr. Charles M. Frankhouser** as president of the joint advisory board of the Fort Wayne Medical Education Program was announced recently by **Dr. Franklin A. Bryan,** coordinator of the program.

Gary Rehabilitation Center First To Be Accredited in Indiana

The Rehabilitation Center of the Methodist Hospital of Gary has just received notice of its accreditation for the next three years by the Commission on Accreditation of Rehabilitation Facilities. This is the first accredited comprehensively planned facility providing both inpatient and outpatient services in Indiana.

Optimist Club Speaker on VD

Dr. David Haines, Warsaw, recently discussed the local Optimist Club's "Project aVoiD," a program aimed at educating young people about venereal disease, with more than 250 sophomores at Wawasee High School.

Pamphlet on Child Abuse Announced

Public Affairs Pamphlet No. 508 is entitled "To Combat Child Abuse and Neglect." Its purpose is to advance new programs for the protection of the battered child and for the rehabilitation of abusing parents. The pamphlet is priced at 35 cents per copy, with rates for quantities. Public Affairs Committee, 381 Park Avenue South, New York City 10016, is the publisher.

Honored at This-Is-Your-Life Program

Dr. Everett Taylor, Upland, was honored by Grant County friends and neighbors at a recent "This Is Your Life" program where he was named Upland's most distinguished citizen. His medical career at Upland began in 1932 and he is still in active practice.

Foundation Scholarships to Continue

The Pharmaceutical Manufacturers Association Foundation has announced that it is continuing its faculty development awards in clinical pharmacology and its clinical pharmacology fellowship program. The Foundation is now seeking nominations for the two programs for the terms beginning July 1, 1975.

Traffic Fatalities Reduced

Highway fatalities to July 21 for the years 1972, 1973 and 1974 stand at 809—910—600. The death toll decrease on the Toll Road amounts to 77%, on the Interstates 57%, on state and federal roads 44%, on county roads 22% and on urban thoroughfares 15%. It is evident that the higher speed roads achieve the largest increase in safety with the new gas-saving speed limit.

Ambulance Society Appoints Myers

Larry Myers, operator of Myers Ambulance Service of Greenwood, has been appointed director of Region 5 of the Ambulance Society of America. Region 5 consists of the states of Indiana, Ohio, Illinois, Michigan, Wisconsin and Minnesota.

Continued

Dr. Russell Baskett, Jonesboro Called "A Pioneer of Education"

When **Dr. Russell J. Baskett, Jonesboro,** retired from the board of the Mississinewa Community Schools June 30, he ended his 17th term as board president and 28th year of service as a board member—the longest tenure of any school board member in Indiana.

Dr. Baskett's school board service began in 1946 when he returned to his private practice after serving in the Army Medical Corp, according to a recent article in the *Marion Chronicle-Tribune.*

"If the cliche 'pioneer of education' fits anyone, it fits Dr. Baskett. During his 28 years as a school trustee, the 64-year-old physician has literally pioneered in legislation that eventually made school consolidation possible in Indiana," the newspaper article stated.

Dr. Matthew McNeely Retires

"Dillsboro will lose the services of its only doctor as **Dr. Matthew J. McNeely,** 74, closes the doors on his practice after 33 years in that town and moves to Bradenton, Fla., where he and his wife, Virginia, have established a home," according to an article in the Aug. 29 issue of the *Dearborn County Register.*

Before coming to Indiana, Dr. McNeely practiced seven years in Cincinnati and seven in Kentucky.

Named National President-Elect

Dr. John M. Miller, director of student health services at Indiana University, Bloomington, since 1962, has been named president-elect of the American College Health Association. The nationwide organization represents campus physicians, nurses and other health professionals responsible for the medical and health care services of the nation's nine million college and university students.

Medical Assistants Announce Workshop; "Your Office: Mess or Success?" Theme

The American Association of Medical Assistants, Inc. Indiana Society, will sponsor an all-day "traveling symposium-workshop" on Sunday, Nov. 3, at the Holiday Inn, Terre Haute. Registration will begin at 9:00 a.m. Theme of the workshop is: Your Office: Mess or Success? The educational program is open to all medical assistants in the area, and offers an opportunity for continuing education, friendships with other medical assistants, and personal enhancement of your skills and profession. Registration deadline is 10-25-74. Please send your pre-registration now to: Neva Y. Arnold, R.N., C.M.A., 5470 E. 16th St. #5, Indianapolis 46218

The schedule is as follows:

9:00 a.m.	Registration
Morning:	"A Place for Everything & Everything in Its Place!"
	"Person to Person"
	"Preparation (H)elp: Piles of Paper!
Luncheon:	
Afternoon workshops:	"The Rhythm Method (Inner Office Communication)
	"Serving Your Bread and Butter: Your Attitude

Please use registration form:

Name: _____ Member _____ 5.00
Employer: _____ Non-member _____ 10.00
Student _____ 7.00
(Fee includes luncheon)

Elected Radiology Fellow

Dr. Joseph L. Morton, Indianapolis, director of radiation therapy at St. Vincent Hospital, has been elected a Fellow of the American College of Radiology.

Dr. Kerr on AMWA Board of Trustees

Dr. Charlotte Kerr, Michigan City gynecologist, recently attended a four-day interim meeting of the American Medical Women's Association in St. Charles, Ill. She is councilor for growth and development on the association's executive board.

Dr. Noel Neifert Honored

At the ceremonies held late this summer marking the 25th year of operation for Camp Koch for Crippled Children near Troy, **Dr. Noel Neifert, Tell City,** was awarded a plaque commemorating his service as medical director for the Camp's entire 25 years.

JCAH Rules Against Enforced Bylaws

The Accreditation Committee of the Joint Commission on Accreditation of Hospitals has ruled that a hospital governing body risks loss of accreditation if it adopts and seeks to enforce bylaws or amendments to staff bylaws that have not been approved by the medical staff. (AAPS News Letter, August 1974)

"Medic Alert" Largest Provider Of Emergency Medical ID Services

Medic Alert Foundation, Turlock, Calif. 95380, is a tax-exempt, nonprofit organization—the world's largest provider of emergency medical identification services. For a membership fee of $7.00 the Foundation provides an alerting device to be worn as a bracelet or necklace which has important medical information engraved on it to alert first aid personnel of allergies or other medical conditions. Such device is of great importance if the wearer is unconscious. A pocket card, with additional information, is also provided. A third service is the maintenance of a medical information data bank on its members. This information is reviewed and renewed annually and is available to physicians on a 24-hour basis by phone.

Physicians may obtain membership applications and educational literature and displays by writing the Foundation. A special container which displays educational folders with membership applications is available, free of charge, for use in doctors' waiting rooms. The Foundation's 18 years of service has resulted in many dramatic instances in which a patient's life was very probably saved by the Medic Alert Alerting Device and the medical information which it contains.

Dr. Norris Named Bicentennial Head

Dr. Max S. Norris was recently named chairman of the Indianapolis Bicentennial Committee. He is also currently serving as president of the Downtown Kiwanis Club and as vice chairman of the Board of Trustees of Butler University.

Deaconess Hospital Addition Opened

The Deaconess Hospital, Evansville, has recently opened a new $3.6 million radiology and cancer center addition.

Dr. Grant Receives Masonic Award

Dr. Benjamin Grant, the first black physician to be admitted to the staffs of Gary hospitals in 1947, was recently presented with the Freedom Award by the Prince Hall Masons of Indiana for his outstanding work in human rights.

New West LaFayette Health Officer

Dr. John R. VanKirk has been appointed health officer for West Lafayette, replacing **Dr. Paul Schmiedicke,** who resigned after serving the city since 1957.

Doctors Accept Invitations to Speak

Hoosier physicians are in great demand as speakers—as the following list will indicate. The doctor who spoke, the topic (if known) and the organization whose meeting was addressed is given.

Dr. Floyd Coleman, Waterloo—Full Gospel Businessmen's Fellowship.

Drs. John Pattison and Vicente Carag, Marion—Sports Medicine Seminar for High School Coaches.

Dr. James M. Wilson, South Bend—New Crisis in Lung Disease—American Lung Association.

Dr. Clarence G. Kern, Lebanon—Kiwanis Club.

Dr. Jerard G. Ruff, Bloomington—Career Opportunities for Girls—Tulip Trace Girl Scout Council.

Dr. Nina C. King, Kokomo—Howard County Diabetes Association.

Dr. Joseph F. Fitzgerald, Indianapolis—The Role of the Dietitian in the Nutritional Management of the Pediatric Patient—Northeastern Indiana Dietetic Association.

Dr. Harry Cochran, Jr., Fort Worth—Indiana State Nurses Association, District I.

Dir. Victor A. Teixler, Indianapolis—Mid-Indiana Association of Industrial Nurses.

Dr. John Scully, Merryville—Antibiotic Therapy—Gary Methodist Hospital Nurses Alumni Association.

Dr. Joseph W. Longacher, Bluffton—Alcoholism—Kiwanis Club.

Dr. Robert C. Keyes, Fort Wayne—Association for Children with Learning Disabilities.

Drs. William C. H. Grimm, Jr., Melvin Faw, Sanford E. Schen, William A. Vincent and Mell B. Welborn, Jr., Evansville—Coronary Care Nursing—Welborn Baptist Hospital.

Receives Presidential Appointment

Dr. Sprague H. Gardiner, Indianapolis, professor of obstetrics and gynecology at the Indiana University School of Medicine, received a United States presidential appointment in July to serve as one of two vice-chairmen of the National Commission for the Observance of World Population Year.

The commission is charged with creating "within the United States a better understanding of the causes, nature, scope and consequences of the problem of population growth, both national and international, and the relationship of this problem to the quality of life," according to the Department of State.

YMCA Honors Dr. H. N. Middleton

The Greater Indianapolis YMCA's most coveted service award, the Red Triangle Plaque, was recently presented to **Dr. H. N. Middleton,** who has been active in the Indianapolis YMCA for 25 years. He served on the metropolitan board for 18 years and was instrumental in developing the Fall Creek branch.

National Antibiotic Therapy Test Scheduled for Rerun Oct. 22-Nov. 1

Hundreds of Indiana physicians will have the opportunity to assess their prescribing skills when they take "The National Antibiotic Therapy Test" (NATT) at 26 hospitals via WAT 21 closed circuit Medical Television Oct. 22 through Nov. 1.

Produced by the Network for Continuing Medical Education (NCME), New York, the NATT is an 80-minute videotape accompanied by a test folder and was first issued last spring. At that time WAT 21, operated by Indiana University School of Medicine, distributed test folders and ran the videotape as a one-time-only "special."

The "rerun" of the NATT will be at 12 noon on Oct. 22, 24, 28, 30 and November 1.

Hospitals in the Indianapolis area which receive WAT 21 telecasts are St. Francis, Community, Marion County General, Methodist, Veterans Administration, Winona Memorial and the I.U. Medical Center. Other "network" members are Methodist and St. Mary Mercy, Gary; St. Margaret's, Hammond; St. Catherine's, East Chicago; Our Lady of Mercy, Dyer; Howard Community and St. Joseph's, Kokomo; Home and St. Elizabeth's, Lafayette; Purdue Student Hospital, West Lafayette; Good Samaritan, Vincennes; Ball Memorial, Muncie; Memorial, Osteopathic and St. Joseph's South Bend; St. Joseph's, Mishawaka, and Bloomington.

Approximately 150 Indiana physicians took the NATT in June as part of the "Family Practice Course" given by I.U. School of Medicine's Division of Postgraduate Medical Education. The "test," designed to be both a self-assessment and a learning experience, was also presented at the AMA's annual convention in Chicago.

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For further information, write or call the Medical Secretary, The University Center, Box 621, Ann Arbor, Michigan 48107, Telephone: 313-663-5522. Brochure is available upon request.

ARNOLD H. KAMBLY, M.D.
Psychiatrist-Director

Dr. Muller Named "Boss of the Year"

Dr. Paul F. Muller, Indianapolis, medical director of St. Vincent Hospital, was recently named "Boss of the Year" by the 500 Classic Chapter of the American Business Women's Association.

Dr. Jackson Serves as Chairman

Dr. Dean Jackson, Angola, served as co-chairman for a series of conferences sponsored recently by the Steuben County Lakes Council. State and federal officials were on hand to discuss their roles in relation to lake area problems and possible solutions.

Dr. Chua New Heart Unit Chief

Dr. Philip S. Chua, Gary, was elected president of the American Heart Association Northwest Indiana Division recently. A past president of the Denton A. Cooley Cardiovascular Surgical Society, Dr. Chua is secretary-treasurer of the Northwest Indiana Surgical Society.

Named Mental Health Director

Dr. Frederick H. Buehl, Vincennes, director of the Knox, Daviess and Martin County Comprehensive Community Mental Health Center located at Good Samaritan Hospital Vincennes, has announced the appointment of **Dr. James A. Koontz,** formerly of Logansport, as associate director of the Center.

Donates Large Shell Collection

A collection of several thousand sea shells from many parts of the world has been given to the Indiana University Museum by **Dr. McKendree C. Pitkin, Martinsville,** former medical director of the Home Lawn Sanitarium. An exhibit featuring shells from the Pitkin collection currently is on view in the I.U. Museum.

Dr. Kendrick Edmonds Retires

Dr. Kendrick T. Edmonds, Bedford radiologist, retired September 1. It was in April 1948, after a two-year residency in radiology at General Hospital, Indianapolis, that Dr. Edmonds and Dr. William Stangle founded the Southern Indiana Radiological Associates which serves the Bloomington and Martinsville hospitals, as well as Dunn Memorial Hospital in Bedford.

Returns From Service in Kenya

Dr. Ernest M. Steury, who has been in medical missionary work in Kenya, East Africa, for five years, has returned to practice at Berne.

Dr. Preston M. Nesbit Dies in Texas

Dr. Preston M. Nesbit, who practiced almost 40 years in Arlington, Texas, died Aug. 22 in All Saints Hospital, Fort Worth, at the age of 71.

Dr. Nesbit, who graduated from the Indiana University Medical School in 1934 and interned at Indianapolis General Hospital, was the first chief of staff of the Arlington Memorial Hospital and served for many years as president of the Tarrant County Cancer Society.

He was a brother of **Dr. L. L. Nesbit, Anderson.**

Dr. Anthony Dowell Named Director of Muncie Center

Dr. Anthony R. Dowell, Muncie, has been named director of the Muncie Center for Medical Education. Dr. Dowell has been engaged in the practice of internal medicine at the Muncie Clinic since 1971. He is also associate director of medical education at Ball Hospital and clinical assistant professor of medicine at Indiana University School of Medicine.

VA Developing Aids for the Blind

The Veterans Administration research program is accomplishing many aids for the blind. A reading device "reads" ordinary print and pronounces the letters audibly. Work is in progress on a lighter weight laser cane that will warn the user of objects in his path. Also in the development stage is an ultra-sonic eyeglass project to enable the blind to perceive objects in much the same way that underwater sonar functions.

New Kosciusko County Health Officer

Dr. George A. Ros, Warsaw, has been appointed Kosciusko County health officer to fill a vacancy created by the resignation of **Dr. David W. Haines, Warsaw.**

Dr. Irvine Page to Be Honored

The American College of Chest Physicians announces that Dr. Irvine H. Page will be one of four physicians to be honored at the College meeting in November. Dr. Page will receive the Presidential Citation. Drs. Benjamin Felson, Robert A. Good and Earl H. Wood will also be honored by Distinguished Lectureships and medals.

Schedule for Upcoming NCME Programs

Here ore the playing dotes and upcoming progroms to be distributed by the Network for Continuing Medicol Education (NCME):

Oct. 7-Oct. 20 EARLY PROSTHETIC FITTING FOR CONGENITAL DEFECTS OF THE EXTREMITIES, with Chorles H. Epps, Jr., M.D., Professor ond Chief of Orthopedic Surgery, Howord University College of Medicine, Woshington, D.C.

CORTICOSTEROIDS: TREATMENT FOR THREE CONNECTIVE TISSUE DISEASES, with Richord H. Ferguson, M.D., Associate Professor of Medicine, and Head of a Section of Rheumatology, Mayo Clinic ond Moyo Foundotion, Rochester, Minn.

OFFICE TREATMENT OF SKIN CANCER, with Rex A. Amanette, M.D., chemosurgeon, member of the Department of Dermatology, University of Tennessee College of Medicine, Memphis.

(Program scheduling subject to chonge)

For more information about NCME, write The Network for Continuing Medical Educatian, 15 Columbus Circle, New York, N.Y. 10023.

Association News

EXECUTIVE COMMITTEE

June 15, 1974

The meeting was called to order at 2:00 p.m. at the Headquarters Building by Dr. Donald M. Kerr, chairman.

Roll call showed the following present: Dr. Joe Dukes, Dr. Gilbert Wilhelmus, Dr. Hugh K. Thatcher, Jr., Dr. William R. Clark, Dr. Arvine G. Popplewell, Dr. Donald M. Kerr, chairman, Mr. James Waggener, Mr. Al Lerner, AMA field representative. Guests were Mr. Lennox and Mr. Oldham of the firm of Lennox, Matthews, Simmons & Ford.

THE MINUTES OF THE MEETING held April 20 were approved upon motion of Dr. Thatcher and seconded by Dr. Dukes.

The Membership Report was reviewed and accepted by consent.

HEADQUARTERS OFFICE

THE SECRETARY EXPLAINED CORRESPONDENCE HE HAD HAD WITH THE GOVERNOR'S OFFICE and the Department of Public Instruction concerning distribution of a publication entitled "Search" in the 7th Grade in some of the public schools

THE SECRETARY ASKED THE PLEASURE OF THE COMMITTEE concerning a ribbon to be given all the attendees at the 125th Anniversary meeting of the Association. Upon motion of Dr. Dukes and seconded by Dr. Wilhelmus, the secretary was instructed to purchase special commemorative ribbons.

THE SECRETARY REPORTED THAT HE HAD SENT LETTERS TO THOMAS M. TIERNEY requesting specific citation in the law that gave the HEW and Social Security the right to control physicians' fees under the Medicaid and Medicare programs.

THE SECRETARY REPORTED THAT THEY HAD HAD FARIS MAILING COMPANY do some of our bulk mailing to the total membership, and the mailing company did not have sufficient funds to handle the postage. It was suggested that a $2,000 deposit be made which this company could use for the mailings of the Association. The deposit of $2,000 was approved by motion of Dr. Thatcher and seconded by Dr. Clark.

THE SECRETARY GAVE A REPORT ON THE TEL-MED usage, which was accepted for information.

MEMBERSHIP REPORT:

ISMA	1974	1973	INCREASE
Full dues-paying	4089	4014	75
Resident	96	59	37
Exempt	517	497	20
Total	4702	4570	132
AMA			
Full dues-paying	3768	3696	72
Residents	94	46	48
Exempt	517	497	20
Total	4379	4239	140
Paid ISMA — Not AMA			
Full dues-paying	321	318	(3) (Decrease)
Residents	2	13	11
Total	323	331	8

THE SECRETARY PRESENTED A CONTRACT WHICH WAS PREPARED BY THE STATE BOARD OF HEALTH to give a grant to the Association to cover certain studies, which they desire to subcontract to the Indiana State Medical Association. By consent, this matter was referred to the Board of Trustees.

A DISCUSSION OF THE PROPOSED MEETING OF THE EXECUTIVE COMMITTEE AND THE BOARD to hold their next meeting, August 23, 24 and 25 at the Inn of Four Winds ensued, and, upon motion of Dr. Dukes and seconded by Dr. Santare, the meeting is to be held at the Inn of Four Winds, with the Executive Committee meeting at 6:00 P.M. on Friday evening.

TREASURER'S REPORT

THE TREASURER GAVE A REPORT of the Funds, Expenditures and Investment Account of the Association. The report was approved upon motion made by Dr. Thatcher and seconded by Dr. Santare.

BUILDING COMMITTEE REPORT

DR. THATCHER REPORTED ON THE PROGRESS of the Building Committee and introduced Mr. Lennox and Mr. Oldham, architects, who presented two sketches for the committee to review. Upon motion of Dr. Thatcher and seconded by Dr. Clark, the architects were authorized to proceed to finalize the plans, and the Committee is to report to the Board of Trustees.

ORGANIZATION MATTERS

THE RECOMMENDATION OF THE FUTURE PLANNING COMMITTEE was taken as a matter of information and referred to the Board of Trustees.

A LETTER FROM THE AMA EDUCATION AND RESEARCH FOUNDATION setting forth that Indiana University received in excess of $34,330.91, was received as a matter of information.

A LETTER FROM THE STATE WELFARE DEPARTMENT suggesting the reappointment of Dr. Maurice Glock of Fort Wayne to the Advisory Committee for Medical Assistance was approved upon motion of Dr. Thatcher and seconded by Dr. Clark.

A LETTER FROM THE INDIANA CHAPTER OF THE AMERICAN ASSOCIATION OF MEDICAL ASSISTANTS, INC., was read, asking the Executive Committee to appoint a medical advisor for the organization was reviewed and, upon motion of Dr. Wilhelmus and seconded by Dr. Santare, Dr. Kerr was named ISMA representative.

A REQUEST FROM THE AMERICAN ASSOCIATION OF MEDICAL ASSISTANTS, INC., for assistance by purchasing advertising space in their program was turned down, by consent, because of lack of funds in the budget for this purpose.

A REQUEST BY DR. J. WILLIAM WRIGHT, JR., for use of the mailing list to announce the fact that his son was joining him in practice was approved by consent.

A REQUEST FROM THE COMMISSION ON MEDICAL EDUCATION AND LICENSURE for the preparation of a special certificate was referred to the Board of Trustees.

A LETTER FROM THE INDIANA ASSOCIATION OF OSTEOPATHIC PHYSICIANS AND SURGEONS, INC., and a copy of their resolution on PSRO was reviewed for the information of the committee.

A LETTER FROM THE UNITED STATES PHARMACOPOEIAL CONVENTION requesting nominations of

specialties in various fields for membership to the U.S.P. Revision Committee, was reviewed and referred to the Board of Trustees.

A LETTER FROM THE INDIANA UNIVERSITY SCHOOL OF MEDICINE REQUESTING NOMINATIONS for a possible director of the Muncie Center for Medical Education was referred to the Board of Trustees by consent, and the secretary was instructed to include an item about this in the next news letter.

A LETTER FROM THE AMERICAN MEDICAL ASSOCIATION CONCERNING THE ASSOCIATION FINANCING representation of medical students to the AMA Annual Meeting in June was approved by consent, and the group is to be given $200 for this purpose.

CORRESPONDENCE BETWEEN DR. SANTARE AND DR. NEATHAMER with reference to the Association's cosponsorship of the Quality of Life Program was reviewed and, by consent, forwarded to the Board of Trustees.

COPY OF THE AMA LEGISLATIVE ROUNDUP DATED JUNE 7, concerning Senator Kennedy's bill on Health Manpower and Medical Education, was reviewed for the information of the committee.

A STATEMENT WHICH IS BEING USED BY BLUE CROSS AND BLUE SHIELD ENTITLED "Statement to Permit Payment of Hospital and Medical Insurance Benefits to Hospital" was reviewed and was forwarded to the Board of Trustees for their action.

A POLICY STATEMENT ADOPTED BY THE NATIONAL ASSOCIATION OF BLUE CROSS Plans on National Health Insurance was reviewed for the information of the committee.

THE SECRETARY READ A LIST OF PHYSICIANS WHO WILL BECOME MEMBERS IN THE FIFTY-YEAR CLUB at the Convention this fall and it was discussed who should be chosen to make a response, if any. By consent, the president is to select the individual.

THE SECRETARY REVIEWED THE PAST GUEST LISTS of those who have been invited to be our guests for the Annual meeting, and, by consent, the same list was approved for the 1974 convention.

THE EDITOR OF THE JOURNAL REPORTED UPON THE OUTLOOK FOR THE JOURNAL for the balance of the year, and it was noted that their deficit appeared to be less than anticipated when the budget was prepared. The report was accepted by consent.

THE SECRETARY READ A LETTER FROM THE STATE JOURNAL GROUP concerning laboratories advertising and, by consent, the secretary was instructed to notify the State Journal Group that we would accept only laboratories operating in the state of Indiana for advertising purposes.

AN APPLICATION FROM A MEMBER for medical defense was reviewed and approved upon motion of Dr. Wilhelmus seconded by Dr. Thatcher.

THE SECRETARY REPORTED ON THE TOTAL COST OF ONE APPROVED MEDICAL DEFENSE case which has not even come to trial as yet; upon motion of Doctor Santare and seconded by Doctor Wilhelmus the doctor is to be informed that the Association has paid all they can afford for this case.

A LETTER FROM THE VIGO COUNTY MEDICAL SOCIETY was referred to the Medical Review Committee.

A LETTER FROM THE ASSOCIATION'S LEGAL COUNSEL concerning the recent staute-of-limitations decision by the Supreme Court was referred to the Board of Trustees.

A LETTER FROM THE MEDICAL LIABILITY COMMISSION OF THE AMA was reviewed and, by consent, was referred to the Medical-Legal Review Committee.

A REQUEST FROM THE COUNCIL ON SMOKING AND HEALTH FOR $25 was turned down and the secretary was instructed to write a letter to point out that we do endorse their program, but funds are not available at this time.

FUTURE MEETINGS

NOTICE OF THE MEETING OF THE AMA COUNCIL ON MEDICAL EDUCATION to be held in Chicago, June 22, was read. Dr. Wilhelmus agreed to attend.

NOTICE OF THE MEETING OF FORUM OF MEDICAL AFFAIRS to be held in Chicago, Sunday, June 23, was taken as a matter of information.

A REQUEST FOR THE PRESIDENT, PRESIDENT-ELECT, JOURNAL EDITORS AND THE EXECUTIVE SECRETARY to be guests of Smith Kline & French Laboratories at the meeting on June 24 was reviewed, and those named who planned to attend.

A NOTICE OF THE MEETING OF THE HEALTH GROUP ASSOCIATION OF AMERICA, INC. scheduled for July 8-10 in Louisville, Ky. was read; no representative will be sent.

AN INVITATION FROM THE WEST VIRGINIA STATE MEDICAL ASSOCIATION inviting the president to attend their annual meeting was approved and Dr. Dukes will attend.

A NOTICE OF THE FOURTH BIENNIAL CONFERENCE ON CONTINUING MEDICAL EDUCATION October 2 and 3 in Chicago was deferred to the August meeting.

There being no further business, the meeting adjourned to meet again at 6:00 p.m. on Friday, August 23, at the Inn of the Four Winds.

Board of Trustees

June 15, 1974

The meeting of the Board of Trustees of the Indiana State Medical Association was called to order at 6:00 p.m., Saturday, June 15, at the Headquarters Office, with Vincent J. Santare, chairman, presiding.

Roll call showed the following:

Dist.	Trustee	
1	Bernard B. Rosenblatt	Present
2	Paul W. Holtzman	Absent
3	Eli Goodman	Present
4	Howard C. Jackson	Absent
5	Cleon M. Schauwecker	Present
6	Paul M. Inlow	Absent
7	John O. Butler	Present
7	Joseph F. Ferrara	Present
8	Richard G. Ingram	Present
9	William M. Sholty	Present
10	Vincent J. Santare	Present
11	James A. Harshman	Present
12	John S. Farquhar, Jr.	Present
13	G. Beach Gattman	Present

Dist.	Alternate	
1	E. DeVerre Gourieux	Absent
2	Betty Dukes	Absent
3	Thomas Neathamer	Present
4	Wm. F. Blaisdell	Present
5	Wm. G. Bannon	Absent
6	Glen Ward Lee	Present
7	Donald C. McCallum	Absent
7	John G. Pantzer	Absent
8	Jack L. Alexander	Absent
9	Max N. Hoffman	Absent
10	Martin J. O'Neill	Present
11	Lloyd L. Hill	Absent
12	Walter D. Griest	Absent
13	Donald S. Chamberlain	Present

Officers & Executive Committee

Joe Dukes	Present
Gilbert M. Wilhelmus	Present
Hugh K. Thatcher, Jr.	Present
Arvine G. Popplewell	Present
Frank B. Ramsey	Absent
James H. Gosman	Present
John W. Beeler	Present
William E. Cast	Absent
Donald M. Kerr	Present
William R. Clark	Present

ISMA Staff

Robert J. Amick	Present
Kenneth W. Bush	Present
Howard Grindstaff	Present
Michael McDermott	Present
James A. Waggener	Present

Approval of Minutes

Dr. Ferrara noted a correction on page 10 of the minutes of April 21, the item concerning the vote on PSRO. He pointed out that he was present but left before the vote was taken and, therefore, did not vote. Also the roll call listed him as absent but he was present.

Dr. Goodman then pointed out that the last paragraph on page 11 begins "Dr. Dukes," but should say "Dr. Goodman." Dr. Goodman also pointed out that in the 3rd paragraph on page 12 the motion was made by Dr. Goodman and not by Dr. Dukes.

Inasmuch as one of the Trustees claimed he did not receive a copy of the minutes, final action was postponed until the Sunday morning session.

Report of President

DR. DUKES—It seems that all I have been doing is travel recently, but I want to report that Tel-Med since we have gone state-wide, we are logging over 800 calls per day.

Concerning the Mediterranean trip, we had 50 people on the waiting list for the October 18 tour, so we have arranged the same trip for departure on September 12 to accommodate these people who are on the waiting list, and all who have been turned down.

As far as travel is concerned, I have been to the Annual Meeting of the Iowa State Medical Association, and one thing I learned there, which we might consider here, is their Blue Shield and their State Society field men are one and the same people. I attended the Ohio State Meeting in Cleveland, the State Dental Society Meeting, the Podiatry Convention, the First District Meeting in Evansville, the Fifth District Meeting, the Fourth District Meeting, and we will have our Second District Meeting in Sullivan Thursday.

Dr. McClure, Chairman of Convention Arrangements, will be at the Board Meeting tomorrow and will give you a report of State Convention plans as of this date.

I forgot to mention I attended the Eighth District Meeting in Anderson, also.

CHAIRMAN SANTARE: I will call on Dr. Peter R. Petrich, a past president and past chairman of this Board, to make a presentation at this time.

Dr. Petrich then presented Dr. Kerr and Dr. Steen with a small token for their long service to this organization.

Report of President-Elect

Dr. Wilhelmus added some information regarding the Tel-Med program, pointing out the most popular tapes.

You will recall at the last meeting yc appointed myself, Dr. Inlow and D Goodman as a committee to study th pamphlet "Your Health and Insurance." This was a six-page brochure; we were to review this and present our recommendation. We would recommend that the pamphlet be turned around somewhat and page 4 of the pamphlet be placed as page 1, so that pages 4, 5 and 6 will be the first pages, and 1, 2 and 3 pages will follow that. The reason is that the back 3 pages have to do with physicians and the first 3 pages have to do with insurance companies. So with your permission, I would like to make a motion that we obtain figures on the cost of the printing of this pamphlet, and go ahead with the procedure.

CHAIRMAN SANTARE: We do have a proposed figure of 2¢ per pamphlet, based on printing 100,000 copies. One of the things brought up at the Executive Committee is that this Commission has spent $1,269.05 over budget. The Chairman further discussed some of the costs and the budget of this Commission.

DR. WILHELMUS: Our committee was instructed, I believe, to see if we should print the pamphlet or not, and our conclusion is that we should print the pamphlet.

DR. SANTARE: Dr. Wilhelmus has made two motions, and I will divide it. Number One is that pages 4, 5 and 6 be put first and pages 1, 2 and 3 be put second in the pamphlet. Doctor Wilhelmus' motion was seconded, put to a vote and carried.

CHAIRMAN SANTARE: The second part of the motion is the recommendation that they print 100,000 pamphlets.

Following discussion, Dr. Wilhelmus moved that we print 100,000 pamphlets.

Chairman Santare pointed out it was the Commission's suggestion that we print them, and the doctors will request these for their offices and they will reimburse us as they did for the Medicare and Medicaid pamphlets.

Dr. Wilhelmus' motion was then seconded.

DR. THATCHER: I think we should have a definite decision made as an amendment to this motion as to how we are going to pay for it.

The matter was then discussed by Chairman Santare, Dr. Ingram and Dr. Wilhelmus.

DOCTOR FARQUHAR: I support the expenditure of $2,179.00, and I would point out that everybody here believes in health insurance as a way to finance the private practice of medicine.

CHAIRMAN SANTARE: The motion has been made and seconded to go ahead, but the matter of how to finance it is still a question.

The matter was then discussed by Dr. Farquhar, Chairman Santare and Dr. Ferrara.

DR. WILHELMUS: Mr. Chairman, I call for the Question. If we are going to spend the money, find out where we can get it and do that later.

The question was put to vote and carried.

The motion was then put to a vote to spend $2,179 for the printing of the pamphlets, which had been seconded, was then put to vote and carried.

DR. WILHELMUS: A couple of small items. We had a physician in Evansville, a 45-year-old man, who just announced his retirement from medical practice to enter IUPUI Law School. His announcement made front page of the local press. His comments were twofold, number one, it's no longer fun to practice medicine; and two, he felt like skilled labor could make as much per hour as he could in medicine.

Local comments from my area concerning the County Society Officers Conference, felt that Dr. Palmer did a very poor job in refuting Dr. Simmons from Washington on PSRO. Also, in clearing up the Medical World News' article, they felt he fell very short in doing this.

I recommend also that the next time a survey is made, such as the one currently being done on malpractice insurance, it not be done by postcards, as this information should not be open as it goes through the mail.

A final item—At the last meeting I brought up the Cost of Living Council action, and I would like to urge us as an Association to urge the AMA to come out soon to show that the cost of medical care and physicians' fees have gone up. I think they ought to come out with graphs showing comparisons of physicians' fees and other costs. I don't think our fees are any more than anyone else's, and maybe not as much. I would like to see us stimulate AMA to bring out figures to compare with other professional people, and I so move then that we do inform AMA that we would like to see this information brought forth.

The motion was seconded.

CHAIRMAN SANTARE: Will you repeat the motion, Dr. Wilhelmus?

DR. WILHELMUS: I move that we urge AMA to come up with a graph or some form of information to show the comparison of physicians' fee rise in the last few years with other professional fees.

The motion was seconded by Dr. Schauwecker.

DR. WILHELMUS: I would like to also add to that, how much it has gone up since Phase IV has been discontinued.

The motion was then put to vote and carried.

CHAIRMAN SANTARE: I will now ask Dr. Kerr to read Resolution 73-23.

The question then of interpreting the intent of Resolution 73-23 was discussed by several, and a motion was made that the cost of printing the pamphlets be taken from the $40,000 account. The motion was seconded and the Question was called for. The Question was put to a vote and failed to carry.

Discussion Continued. The matter was further discussed by Dr. Ingram, Dr. Harshman, Dr. Santare and Dr. Farquhar.

CHAIRMAN SANTARE: We do have a motion on the floor that has been seconded, that the money for these pamphlets be taken from the Speakers' Bureau Fund, and the money from the physicians ordering these pamphlets be returned to the Fund as they are sold.

The motion was further discussed then by Dr. Kerr, Dr. Dukes, Dr. Santare and Dr. Farquhar.

The motion was put to a vote and carried with one dissenting vote.

CHAIRMAN SANTARE: I will now call on the Treasurer for his report.

CHAIRMAN SANTARE: Dr. Chamberlain, did you have a question?

DR. CHAMBERLAIN: I would like to discuss the Convention Program before our formal discussion with the Chairman tomorrow. The people in my part of the state sometimes wonder what their dues money is spent for. The proposed schedule for the 1974 Meeting appears that it will take a computer for a doctor to figure what his schedule will be. I notice the Reference Committees and the golf tournament are scheduled for the same time. If you are not a golfer, of course, this makes no difference; and the football game is scheduled on Saturday. If you are not a graduate of I.U. then there is no reason to stay in Indianapolis to see a football game. Our people will probably go home on Saturday. Sunday, unless you are a Radiologist, or have a special interest in Pediatrics, or you are over 50 years in the Association, or you are a past president, you may wind up with an evening. So Sunday is pretty well eliminated. We are now on Monday and this attracts certain specialties, of which I am not associated, so I will pass Monday very quickly. I am now at 4:00 o'clock on Monday afternoon for our people who have gone home on Friday, they are now coming for their part of the meeting on Monday. Then, you have to stay over Monday for a meeting Tuesday afternoon. What I am saying is, I think the meeting is spread out over too long a period of time, and that you're going to find doctors driving in and out for those particular reasons they might have for attending the meeting.

CHAIRMAN SANTARE: We will take this as a matter of information, Dr. Chamberlain, and discuss it again when Dr. McClure is with us tomorrow.

I will now return to the agenda and ask Dr. Thatcher to give his report.

Treasurer's Report

Dr. Thatcher reviewed the investments of the Association, the expenditures of the various funds, fund balances, and compared the expenditures with the budget figures. In reporting on the investment account, Dr. Thatcher pointed out that some of the accounts were drawing rather low interest and were not too active, and moved that the Board refer the matter of the Student Loan fund back to the Student Loan committee, with the proper and necessary investigation prior that we invest this in something that will be more renumerative to us. The motion was seconded, put to a vote and carried.

Dr. Thatcher then continued with a detailed report of the various funds and moved the approval of his report.

The motion was duly seconded, put to a vote and carried.

DR. THATCHER: I have a few recommendations I would like to make at this time. I would hope that members of the Board who are appointed as liaison representatives to our various commissions would try to keep a thumb on their expenditures. I believe that we are going to have to revise many items in our budget for the coming year due to inflation. As far as the retreat is concerned, while it is being charged to a Commission now, I do not think it should be charged as a commission expense, but made a separate item in the budget. All in all I think we are going to have to take a very close look at our budget for the coming year as to the fiscal impact that will have upon our income.

CHAIRMAN SANTARE: I am informed by the Secretary that it is not in the province of the Student Loan committee to decide about investments; that is a matter for Board disposition. Therefore, I would suggest this Board direct the Treasurer to see if these funds can be placed in securities which give a better interest rate, and if there is no objection, I will ask the Board to accept this as a motion.

Following a discussion, a motion was made that the Treasurer research this matter and bring it back to the Executive Committee. The motion was duly seconded, put to a vote and carried.

DR. THATCHER: Mr. Chairman, the Executive Secretary calls to my attention that we passed a motion that referred to the Student Loan committee, the question of reinvestment of their money; I would move, therefore, that this matter be brought back from the table and be voted on. Motion duly seconded, put to a vote and carried.

The original motion was then put before the Board and they voted not to refer this back to the Student Loan Committee but to refer it back to the Treasurer, who will report back to the Executive Committee with the authority to reinvest the funds.

CHAIRMAN SANTARE: I will now call on the Chairman of our Medical Review Committee, Dr. Beeler.

DR. BEELER: Thank you. The item presented to our committee, as you may remember, was whether or not the monies provided for the Medical Legal Defense Fund, should be continued, and what our advisers on the legal side of the committee thought about it. We had a meeting and it was the unanimous feeling of the lawyers that this fund should be continued. That there should be no expenditures at all for anything toward legal defense for medical-legal reasons, but that there should be funds available for things. First, to assist some member if he has a legal question. The attorneys felt that the monies probably should not be spent in this way because, one, nearly every doctor has money available to him from his own premium that he pays for malpractice defense, and, therefore, we are just more or less providing extra funds, which really don't need to be used this way. So, the answer to your question, at least our committee felt that the funds should stay there, it should grow, where it should be used for answering questions not pertinent to malpractice questions, but the money should not be paid for malpractice defense, and if the fund gets big enough that this money should be used for legislation to try to change the existing Indiana laws for malpractice; and this is something, to be quite frank, I think is going to happen. I think the three lawyers that were with us are all senior men. They are all good, they have all been involved in medical legal defense for quite awhile. It was their feeling that the time was probably not right for legislation, but they suggested that this fund be kept so that it could be used for that. I think, Mr. Chairman, that this is the answer of your committee, and I hope that it sums it all up for you.

DR. THATCHER: I move that we accept the report of the committee.

The motion was then duly seconded. The motion was put to a vote and carried.

DR. THATCHER: I would move that the appropriate changes in the Bylaws be formulated for presentation to the House of Delegates in October. The motion was duly seconded. Following a lengthy discussion, in which Dr. Ingram opposed the proposed change, Dr. Thatcher then moved the Question. The motion on the Question was put to a vote and carried.

CHAIRMAN SANTARE: We will now

revert to the original motion. Dr. Thatcher has moved that Chapter 34, Section 3 be referred to the Commission on Constitution and Bylaws with the request that they meet with Dr. Beeler to prepare a proposed change of this Section for submission to the House of Delegates at the next Convention. Following considerable additional discussion the motion was put to a vote and carried.

DR. KERR: We had a letter from James Stewart concerning the case in Lake County, which was concerning the Statute of Limitations of medical malpractice. This case was settled in our favor in the court of appeals, but was overturned by the Supreme Court. The letter suggests that it might be well to draft legislation which would dissolve this law.

CHAIRMAN SANTARE: The Executive Committee did discuss this and took action to ask that the Board enter into the matter that this letter be sent to these attorneys in an attempt to draft lawful legislation.

Motion was made, seconded, put to vote and carried.

CHAIRMAN SANTARE: We will now call on the Trustees for their District Reports.

1st District — Dr. Rosenblatt: — No special report.

2nd District — Dr. Holtzman: — In the absence of Dr. Holtzman, Doctor Dukes said the next meeting would be in Vincennes in 1975.

3rd District — Dr. Goodman: No report.

4th District — In the absence of Dr. Jackson, Dr. Blaisdell said there was no report.

5th District — Dr. Schauwecker: Dr. Schauwecker reported on the May meeting as being successful, and stated that the 1975 meeting would be in Terre Haute.

6th District — Dr. Lee: No report.

7th District — Dr. Butler: We have a request for remission of dues for a physician for medical reasons, and I move that his dues be remitted. Motion was seconded, put to a vote and carried.

DR. FERRARA: Dr. Ferrara reported that the 7th District meeting was held at Speedway Motel June 5, and the Trustees and Alternate Trustees were re-elected. Dr. Ray D. Miller of Martinsville was named president for the coming year, and Morgan County would be the host.

8th District — Dr. Ingram: Our meeting was held May 29 at the Anderson Country Club. Governor Bowen was our speaker; and the 1975 meeting will be in Portland.

9th District — Dr. Sholty: We had our meeting Thursday at the Frankfort Country Club, and each member of our district on the state commissions reported, which added a lot to our meeting. The Jasper-Newton County Society will be our host in 1975.

10th District — Dr. O'Neill: the 1974 District meeting will be held Sept. 25.

11th District — Dr. Harshman: Our meeting will be held on Sept. 18 at the Holiday Inn in Logansport.

12th District — Dr. Farquhar: I would like to call your attention to the fact that our annual meeting has been moved to September 19, and will be held at the Marriott Inn in Fort Wayne. This completes my report, but I would like to be on the agenda sometime to talk about the Indiana Commission on Emergency Services.

CHAIRMAN SANTARE: Do you want to take that time now? Motion was duly made and seconded, put to a vote and carried, to let Dr. Farquhar discuss this at this time.

DR. FARQUHAR: You will remember at the last General Assembly they enacted a law on Emergency Medical Services, which set up a commission with 11 members, 2 physicians, with myself as chairman. We have undertaken the job of building a system for Indiana. We must submit by the end of this year a set-up of system regulations on quality of pre-hospital care. This will involve the training of emergency medical technicians and onboard equipment for ambulances and vehicular standards as minimal. I want to bring to your attention certain facts, that the philosophy that this Board will operate under is going to be the philosophy that local options and local decision-making should be preserved as much as possible. Within every region of the state, there should be a regional plan through Comprehensive Health Planning, if it has been established, and through Regional Emergency Council if there is no Comprehensive Health Agency. We hope to have most of this work done by Oct. 1; and I hope to bring the deliberations and decisions of the commission to this Board and to the House of Delegates, so that medicine can pass on this first.

I want to mention one other thing at this time—there is a disagreement between the Commission and the IHA, which has to do with trauma centers.

We do not have very good records as to the number and type of injuries, and we hope to get a method established whereby we will get some accurate information, rather than wild guesses, which has been used in the past. I want you to be aware of these facts and the philosophy, and be aware of what is going on, so that at future meetings I can bring you up to date.

CHAIRMAN SANTARE: Thank you, Dr. Farquhar. Dr. Blaisdell?

DR. BLAISDELL: Before you pursue your agenda, I want to back up to the 4th District. Our 4th District Meeting was held last Wednesday, and Dr. Jackson conducted the meeting, and the topic of discussion was PSRO.

13th District — Dr. Gattman: Our meeting is coming up September 11, and our program is undecided.

CHAIRMAN SANTARE: I will now call on Dr. Kerr for his report of the Executive Committee:

DR. KERR: We had some 56 matters, and I will condense them unless you ask specific questions.

A publication entitled SEARCH came into the hands of Mr. Waggener with the report that the publication has been distributed to school children at the 7th grade level. This publication pictured the doctor as a werewolf and downgraded the practice of medicine. Mr. Waggener sent this publication to the Governor with a letter, and the Department of Public Instruction has taken action to prevent this type of material being distributed in the future.

The next matter is a proposed contract between the Indiana State Medical Association and the State Board of Health. They are proposing to use some students, and have submitted a contract involving a total expenditure of $26,500. $6,500 has already been committed and this relates to some college students who will be studying the role of local health departments and what they do. $20,000 is for us to employ someone to go out about the state and study local health departments, private medical services, the State Board of Health, and the interrelationship between all these people and what kind of effective and helpful service can be developed to produce in coming years good medical care. The contract provides that from this organization three elected officers shall be the steering committee, and that they would report quarterly. We ask: do you want us to get into this or not? The deadline for us to make a decision is this coming Monday.

DR. FARQUHAR: I think we should do it, and I endorse getting into it as quickly as possible, and I so move.

CHAIRMAN SANTARE: Dr. Dukes, the motion has been made that we accept the funds, and it has been seconded. Discussion? The motion was debated, put to a vote and carried that the ISMA participate in the contractual arrangement.

DR. KERR: The next matter was referred by the Future Planning Committee. I shall review their letter. The following items were submitted: (1) The revision of the commission structure for more effective operation. (2) Commission and committee structures, their purpose and goals be reviewed. (3) The need for closer relationship with medical students. (4) Priority should be set on the committee's undertakings with the notation that dealing with current matters is not the function of the committee. (5) Redividing the districts of the State Medical Association in view of the patterns of practice and other factors.

The committee then discussed Resolution 73-11, which deals with the possibility of two meetings of the House of Delegates. The committee raised legal questions as well as taxable questions and suggested that this be brought to the attention of the Executive Commitee for their consideration. A motion was made and carried by the future planning group to oppose the idea of two meetings of the House of Delegates per year.

A motion was also made by the Future Planning Committee that at the next House of Delegates' meeting, the delegation be polled with the recommendation that ISMA continue with their regular fall meeting, but that the poll be an opinion survey of a one-day meeting in the spring to consider urgent matters which have accumulated, legislative matters, new resolutions, etc. The motion was seconded and passed.

The next item discussed was the Annual Convention and the loss of income. Dr. Haley pointed out that the Indiana Academy of Family Practice annually held a very successful meeting, and this was confirmed by Dr. Petrich. The idea was suggested that the IAFP and ISMA consider joining together in a State Convention. The committee urged that contact be made with the executive secretary of the IAFP to get reaction on such a proposal and that this recommendation be brought before the Board of Trustees and the Commission on Convention Arrangements.

They also discussed the letter from Dr. Ignatz, who suggested many changes in the Convention format.

DR. DUKES: Suggested that he had discussed the feasibility of the Indiana Academy of Family Physicians joining with the Indiana State Medical Association in an annual convention. He pointed out that it might be well to have three members of this Board to meet with a like number of the Academy of Family Practice Board to see what they could come up with.

CHAIRMAN SANTARE: The motion is that we have three members of our organization to meet with three members of the Indiana Academy of Family Practice Board to come up with a meeting date.

Discussion by Dr. Schauwecker and Dr. Gattman. The motion was duly seconded, put to a vote and carried.

DR. KERR: We have a request from the Commission on Medical Education and Licensure, which has a congratulatory resolution for presentation to an Indiana physician, namely Dr. Merritt Alcorn.

CHAIRMAN SANTARE: Do we have a motion? It has been made and seconded that the ISMA participate in the endorsement of this Resolution. The motion was put to a vote and carried.

DR. KERR: We now have a letter from the United States Pharmacopeial Convention for recommendations of membership to various revision committees. We leave this list with you and if you have suggestions, we will be happy to have them, or would you care to make your own recommendations. or would you like this to be in the hands of the president to submit to a committee to make his own recommendations.

CHAIRMAN SANTARE: We have a motion which has been made and seconded that the president appoint a committee to be responsible for these recommendations. The motion was put to a vote and carried.

DR. KERR: The next item we have is a letter from the Indiana University School of Medicine, who is seeking a qualified person for the position of Director of the Muncie Center for Medical Education. They are seeking our assistance in locating candidates for this position. A candidate from Dr. Ingram's district was discussed and Dr. Ingram agreed to discuss this with the candidate to see if he would be interested in having ISMA recommend him for this position.

DR. KERR: We have a matter of correspondence between the president and Dr. Neathamer concerning the Association lending its name to the Quality of Life program recently held in Indianapolis. According to the correspondence, a person on Dr. Neathamer's commission raised the question as to why we would co-sponsor a meeting with an agency that had not been approved by the Commission on Voluntary Health Agencies.

The co-sponsors were reviewed. Doctor Goodman moved that it be the policy of this Association to respect the findings made by our Commission on Voluntary Health Agencies.

The motion was discussed by Dr. Santare, Dr. Petrich, Dr. Gattman, Dr. Dukes, Dr. Farquhar, Dr. Thatcher, Dr. Neathamer and Dr. Kerr. The motion was finally put to a vote and carried.

DR. KERR: I believe we have distributed a form relative to the statement to permit payment of hospital and medical insurance benefits to hospitals. Dr. Thatcher brought this to our attention this afternoon, and it appears to be highly objectionable in many aspects. You will note the authorization form permits disclosure and release of other information to Mutual Hospital, Inc. and Mutual Medical Insurance, Inc.

The matter was discussed by Dr. Thatcher, Dr. Harshman, Dr. Santare and Dr. Farquhar.

CHAIRMAN SANTARE: Dr. Farquhar, what specific action do you want this Board to take?

DR. FARQUHAR: Let's take the legal defense money and get an injunction against the use of these forms; that would be good. The motion was seconded. The motion was further discussed by Dr. Kerr and Dr. Santare.

CHAIRMAN SANTARE: Can I suggest that this be read carefully by a subcommittee of this Board, and let's reconsider it tomorrow. I think we are looking at this thing in many ways. I think that Dr. Harshman's point was well taken. I would suggest a committee of three, consisting of Dr. Harshman, Dr. Gosman and Dr. Goodman to consider this and bring it up at our Sunday session.

DR. KERR: That completes my report, Mr. Chairman.

CHAIRMAN SANTARE: I will now call on Dr. Petrich, Chairman of our Committee to Establish a Not-for-Profit Corporation to do peer review.

DR. PETRICH: You do have in front of you an article entitled Indiana Medical Education Development Information Center, Inc., which lists the purposes which I have previously discussed with this Board; also the Bylaws of the organization and Mr. McDermott has pointed out the fact that immunity would probably not hold up, but even if it's not legal, I feel it would be (1) a possible deterrent to many people who would consider litigation. (2) Should such legislation be enacted, it would be a part of our Bylaws already, and (3) Most of the Bylaws have to do with JCAH review of hospital practice by physicians. Staff members in hospitals have clauses that are almost identical to this, and for that reason I included it. I would be glad to answer any questions, but I commend it to you and hope that it is endorsed by this Association, so we can incorporate it in the very near future. It is going to cost us money.

Following a short discussion, Dr. Goodman moved to table the motion until Sunday. The motion was seconded, put to a vote and carried.

CHAIRMAN SANTARE: I will now call on Dr. Thatcher for a report of the Building Committtee.

DR. THATCHER: At the last meeting you gave us permission to employ an architect, and we have decided to go with the original architects for the existing building. We have met with them. They have prepared one set of drawings, and we asked them to go back and prepare another set, which might be less expensive than the first presentation. We have the two sketches on the wall and I will explain them to you. Following presentation of the plans by Dr. Thatcher and the approximate costs, the question was thoroughly discussed in detail as to the pros and cons between the smaller building and the larger building. The discussion ensued as to the matter of expense, and it was felt that if we went to the larger building, it would have to be approved by the House of Delegates, and perhaps both plans would have to be approved by the House of Delegates, for that matter.

Following discussion, the motion was made by Dr. Goodman that the drawings be made available to be looked at to-

night and tomorrow morning, and then table this matter until tomorrow's session of the Board. The motion was seconded by Dr. Schauwecker, put to a vote and carried.

CHAIRMAN SANTARE: Recognized Dr. Harshman.

DR. HARSHMAN: I would like to introduce our guest, Mr. Al Lerner, our new AMA field representative from Chicago.

There being no further business, the Board recessed until 9:00 a.m. Sunday morning, June 16, 1974.

Board of Trustees

June 16, 1974

Dist.	Trustee	
1	Bernard B. Rosenblatt	Present
2	Paul W. Holtzman	Absent
3	Eli Goodman	Present
4	Howard C. Jackson	Present
5	Cleon M. Schauwecker	Present
6	Paul M. Inlow	Absent
7	John O. Butler	Present
7	Joseph F. Ferrara	Present
8	Richard G. Ingram	Present
9	William M. Sholty	Present
10	Vincent J. Santare	Present
11	James A. Harshman	Present
12	John S. Farquhar, Jr.	Present
13	G. Beach Gattman	Present

Dist.	Alternate	
1	E. DeVerre Gourieux	Absent
2	Betty Dukes	Absent
3	Thomas Neathamer	Present
4	William F. Blaisdell	Absent
5	William G. Bannon	Absent
6	Glen Ward Lee	Present
7	Donald C. McCallum	Absent
7	John G. Pantzer	Absent
8	Jack L. Alexander	Absent
9	Max N. Hoffman	Absent
10	Martin J. O'Neill	Present
11	Lloyd L. Hill	Absent
12	Walter D. Griest	Absent
13	Donald Chamberlain	Present

Officers and Executive Committee	
Joe Dukes	Present
Gilbert M. Wilhelmus	Absent
Hugh K. Thatcher, Jr.	Present
Arvine Popplewell	Present
Frank B. Ramsey	Present
James H. Gosman	Present
John W. Beeler	Present
William E. Cast	Absent
Donald M. Kerr	Present
William R. Clark	Present

AMA Delegates and Alternates	
James A. Harshman	Present
Eugene F. Senseny	Present
Malcolm O. Scamahorn	Present
Patrick J. V. Corcoran	Present
Lowell H. Steen	Present
Joseph E. Walther	Absent
Lall G. Montgomery	Absent
A. Alan Fischer	Present
Ross L. Egger	Present
Kenneth O. Neumann	Absent
Thomas C. Tyrrell	Absent
Peter R. Petrich	Present
Sprague H. Gardiner	Present
Myron H. Nourse	Absent

Guests	
Dr. F. Schoen	Absent
Dr. Glen McClure	Present
Dr. Fred Smith	Present
Dr. David Crane	Present
Dr. Donald E. Wood	Absent
Mr. Al Lerner	Present

ISMA Staff	
Robert J. Amick	Present
Howard Grindstaff	Present
Mike McDermott	Present
Kenneth Bush	Present
James A. Waggener	Present

CHAIRMAN SANTARE: Since we all had a chance to look over the minutes, I now place them before you.

The minutes were approved upon motion of Dr. Ferrara and seconded by Dr. Gosman.

CHAIRMAN SANTARE: I will now call on Dr. McClure, chairman of the Commission on Convention Arrangements for the report of the 1974 Annual Meeting.

DR. McCLURE: Then outlined step-by-step the program as envisioned for 1974 meeting, which evoked discussion on the part of the Board. However, no action was taken on her report, other than to commend her for a job well done. Dr. McClure did make a recommendation that the immediate past president of the Association always be a member of the Convention Arrangements Committee, because they are the ones who have been through the chairs, have visited other states and many times have some very valuable ideas, which could be incorporated into our Convention.

CHAIRMAN SANTARE: I will now call on Dr. Fred Smith, chairman of the IMPAC Board.

DR. SMITH: Dr. Smith proceeded to outline the activities of the IMPAC Board, and their meetings and enlargement of the Board by adding women members to it. He announced they had another meeting scheduled for July 10. Dr. Smith announced that the highest membership in IMPAC was in 1968 with 3,170 members, while in 1973, we only had 2,210 members. In view of this, we felt something had to be done and this was one of the reasons we increased the membership on the Board to include the women of the state.

I am happy to report, however, as of this date we have 2,344 members, which is 134 more than all of last year. I am setting a target for 3,000 members this year and I believe we can make it.

Dr. Smith went ahead to name ladies who he would like to have nominated to membership on the IMPAC Board and received some suggestions for vacancies.

CHAIRMAN SANTARE: Do we have a motion that this Board nominate these people for the IMPAC Board? The motion was duly made, seconded, put to a vote and carried.

CHAIRMAN SANTARE: I will now call on Dr. James Gosman, who has a matter to bring before the Board.

DR. GOSMAN: I received a letter from Birch Bayh concerning the administration impounding of funds for research in health. The Senator also enclosed a copy of a letter that he had written to Senator Magnuson, Chairman of the Appropriations Committee and requested that the Association take the position of writing a letter to the President and to the director of the Office of Management and Budget, complaining about withholding $100,000,000 under the Bill 93-192, which funds were for use mainly in the field of health activities.

Dr. Gosman then moved that the State Medical Association send a letter expressing our concern in this particular area alone. The motion was duly seconded.

The motion was then discussed by Dr. Dukes, Dr. Goodman, Dr. Farquhar, Dr. O'Neill and Dr. Ingram. Dr. Goodman then asked Dr. Gosman if he would be willing to accept an amendment to his motion, which would incorporate Dr. Popplewell's thinking that we should recommend an addition. Also that there be an extension on the period of time for reasonable expenditure of these funds.

Dr. Gosman accepted the amendment to his motion. Further discussion then ensued. The motion was then put to a vote and carried by a hand vote of 9 to 6.

CHAIRMAN SANTARE: I will now call on Dr. David Crane, chairman of the Committee on Public Information.

DR. CRANE: The Speakers Bureau is now operational. We have six speakers, including Stanton Evans and Mr. Cortney Smith, who is a part-owner of a radio station in Mount Vernon, Mr. Jack Post, who is a retired manufacturer in the state of Michigan and Mr. Paul Page, who is with WIBC here in Indianapolis, and Dr. Michael Act, who is a professor of education at Indiana University. Dr. Crane asked for assistance from the Trustees in the northern part of the state, to line up some speakers in that particular area.

I would now urge you to contact the county societies in your area and tell them of the availability of these speakers, and to make dates for them. The placement of the speakers will be handled by a special speakers' bureau, which in addition to booking the speakers, will make an evaluation of the reaction of the audience, whether or not they are saying what we want them to say, and I think we are going to have a probationary period, that is, if any speaker doesn't work out for a few months, we can, if

we found out he couldn't make necessary corrections just simply eliminate him as a speaker from the bureau.

The speakers will be handled by the Hopkins Syndicate at Mellott, Ind. If there is any question, just contact them through the ISMA and they will be sure to get the information forwarded to the Bureau.

Many questions were asked of Dr. Crane as to details of the operation of the Speaker's Bureau, which he answered.

CHAIRMAN SANTARE: Thank you, Dr. Crane, for a very complete report. I will now call on Mr. Lerner, field representative from AMA.

MR. LERNER: Very briefly I would like to relay to you Congressman Wilbur Mills first public statement at the House Ways & Means Committee on National Health Insurance. He committed himself to three points, (1) That any national health insurance program must have a system for utilization review. (2) In any legislation there must be a system for reviewing payments to hospitals, and also must be a system for reviewing payments to physicians. But there is some good in this thing and based on his conversation it seems that Mills is not locked into an inflexible position support of his compromise with Kennedy and I quote the *American Medical News* "Representative Mills declared his primary concern is that the poor receive at least as good medical services as the rest of the people. He said he wanted to avoid a bill that would provide nothing more than catastrophic which would cover only 5% of the needs. Our Staff feeling is that in light of Watergate and some other things that are happening in Washington, in terms of National Health Insurance, the forecast ranges from anywhere from a full national plan this year to nothing before 1978." Thank you.

CHAIRMAN SANTARE: If there are no questions of Mr. Lerner, we will proceed with our agenda for a report by the AMA delegates. I want to bring out that it is a matter of policy, which has been adopted by this Board, the following: (1) That our delegation consists of the AMA delegates, the alternates, the president of the State, the president-elect and the chairman of the Board. That the chairman of the delegation is the president of ISMA, and that the delegates and the alternate delegates select a floor leader before the annual meeting each year. I wish to bring up also that we as a Board can direct the AMA delegation as far as policy is concerned, but that we leave the politics to the delegation. The delegation at a meeting prior to the Board has selected Dr. Eugene Senseny as their floor leader for the coming year.

The AMA delegates then proceeded to cover all the matters in the handbook, which they have been assigned to report upon, including reports and various resolutions. In discussion of Resolution 43, a motion was duly made and seconded that the ISMA oppose this Resolution entitled "Compulsory Surgical Practices for Social and Eugenic Purposes."

Following discussion, it was moved by Dr. Goodman, and seconded by Dr. Sholty that this motion be tabled indefinitely. The motion was put to a vote and carried.

Following a reporting of the delegates on the matters to come before the AMA House, the Board discussed these as they went along and gave them their opinions on the actions that the delegates should take in voting upon the various reports and resolutions.

The next item brought up by the delegates was the problems they thought they might face in obtaining the reelection of Dr. Donald E. Wood to the AMA Board of Trustees.

The *Medical World News* Article was reviewed, as well as Indiana's stand on PSRO. Dr. Senseny pointed out that chances are the House would vote for a simultaneous election of trustees, which would mean that all their names would appear on one ballot, rather than running for the slot as in the past.

CHAIRMAN SANTARE: Dr. Goodman, you are recognized.

DR. GOODMAN: I would move that it be the consensus of this Board that our delegation give Don Wood its full support, and unlimited support in his effort for reelection as trustee. The motion was duly seconded, put to a vote and carried.

CHAIRMAN SANTARE: Dr. Schauwecker?

DR. SCHAUWECKER: I move an acclamation for AMA delegation.

CHAIRMAN SANTARE: We can accept that by consent. I will move on to the report of the Board committees.

The Board Liaison Committee with the I. U. School of Medicine — Dr. Wilhelmus: — No report.

Board Liaison Committee with Blue Cross — Dr. Harshman: No report.

Board Liaison Committee with Blue Shield — Dr. Holtzman: — No report.

Board Committee for the Study and Implementation of Governmental Medical Programs — Dr. Gosman: — No report.

Board Committee on Economic and Fiscal Matters — Dr. Goodman: Only announcement that there will be a meeting of the committee during our next Board meeting at the Inn of the Four Winds. Notices will be sent out, the meeting will probably be held on Friday evening.

Committee to Work with Health Careers — Dr. Butler: No report.

Board Liaison Committee with ISMA Auxiliary — Dr. Sholty: Dr. Sholty reported on the Auxiliary's Annual Meeting at Brown County.

Board Liaison Committee with The Journal — Dr. Farquhar: No report.

Blue Shield Nominating Committee — Dr. Santare: — No report.

Special Subcommittee to work with the Commission on Convention Arrangements — Dr. Ferrara — No report.

Proposed Controlled Substances Act Regulations — Dr. Ferrara: Dr. Ferrara — I have just been handed a note from Mike McDermott that a new hearing is being called by the Pharmacy Association to review the proposed regulations, which we had before us sometime ago.

CHAIRMAN SANTARE: If there are no questions, we will go on to the tabled procedures. Dr. Ingram, you were a Committee of One for consideration of a prospect as Director of Indiana University School of Medicine branch in Muncie.

DR. INGRAM: I discussed this with Dr. Egger and he is willing to have his name submitted; therefore, I move that the Association does submit the name of Ross Egger for this position. The motion was duly seconded and carried.

CHAIRMAN SANTARE: I will now call on Dr. Gattman for his report concerning the resolution as to M.D. assistants and nurse practitioners.

DR. GATTMAN: I have prepared a rough typed resolution, which, in effect, states that physician assistants and nurse practitioners are a reality in the state of Indiana. The ISMA recommends (1) That they be graduates of certified programs. (2) That only one certified graduate be allowed to work for a doctor. (3) That they be under the direct supervision of a physician and all of this pertaining to medicine. (4) That they be allowed to work in the hospitals, but will not be permitted to write orders for treatment to be made, unless countersigned by the doctor within 24 hours. I am sure that much more can be added to this and I certainly hope that there is.

I propose that this be presented to the House of Delegates, so they will have a chance to discuss it, review it and come out with something specific. It is my hope that the Board will recommend that such resolution be introduced, with the stipulation that we are not endorsing the resolution, that the first whereas will say that the Board is asking for an opinion from the House of Delegates, and it is introducing this resolution to stimulate quality from the House of Delegates.

CHAIRMAN SANTARE: I believe this is a motion we continue in this fashion.

The motion was seconded, followed by discussion, and put to vote and carried.

CHAIRMAN SANTARE: I will now call on Dr. Gosman, who has a letter which I think should be referred to this Board.

DR. GOSMAN: This letter was addressed to me personally, it comes from Methodist Hospital and it comes from

Dr. Rosenberg, who is in charge of the Education for Pediatrics. The last two and one half years Methodist Hospital, with the full support and coordination of the Division of Continuing Education of the Indiana University School of Nursing, has sponsored a very successful pediatric nurse practitioner program. Dr. Rosenberg feels that the time is now here for them to expand this operation into the area of school nurses. In other words, he is asking for the endorsement of this Association to expand this program into this area.

CHAIRMAN SANTARE: This came before the Executive Committee. Some of the thoughts that came out in the meeting were (1) The Academy of Pediatrics, I believe, has withdrawn its endorsement of the nurse practitioner concept. (2) We felt that in this particular instance that Dr. Rosenberg was equating nurse practitioners and school nurses, and we felt that they were not equivalent, whether he put them in category 1 or 2. (3) He is talking about Lake County. The Nursing Association and the School of Nurses and what-not are so rich in grants from the State Board of Health, the Regional Medical Program and Comprehensive Health Planning that they prefer to go to Denver for their school nurse reeducation rather than come to Indianapolis; so, because of these particular things that came out of the executive committee, we thought this should be referred to the Board for discussion, or at least sent to a committee for further evaluation. Is there a discussion?

Dr. Gosman moved and Dr. Farquhar seconded that the Association endorse this program. The motion carried.

CHAIRMAN SANTARE: We did have a report on rural health, and Dr. Harshman wanted an opportunity to read it over, the technical proposal, the development and implementation of a comprehensive approach to alleviate rural medical manpower shortages in the state of Indiana, submitted by the Department of Community Health Sciences, Indiana University School of Medicine and the ISMA. Has everyone had the opportunity of reading this?

DR. GOODMAN: I read this with great care and I think that it is well prepared, I saw nothing wrong in it, and if it is called for, I move that it is adopted.

CHAIRMAN SANTARE: Is there a second to the motion? The motion was seconded and passed.

CHAIRMAN SANTARE. The next item is the building committee. We have had the drawings posted, and we have a number of alternatives. One is to approve the partial addition. The other, is to approve the whole addition or the other is to disapprove or any other intermediate determination. Dr. Thatcher, did you want to say any more on this?

DR. THATCHER: I would just like to have an action on the part of the Board, because we have told the architects that we would try to have information in their hands on which direction we would go, so that they may do additional studies before they come back to our committee, and report to the Board at your August meeting. What I want is a Board assessment of this thing, a decision on whether you go for the 16,000 square feet or whether you go for the 10,000 square feet. Again, the 16,000 feet with the area involvement, etc. being included in that the architect's estimate is $500,000, the lesser enlargement is something between $250,000 and $300,000, plus the exterior costs.

The Board then discussed at length the new building plans.

DR. GOSMAN: I would like to make a motion. I would like to move that we go for the 16,000 square-foot addition; that we go for moving out the present heating and air-conditioning and get a new unit to satisfy the entire building, this plus the new; and that we proceed with architectural plans, and the building committee be authorized to get a contractor and ask what it would cost and present this all to the House of Delegates in October.

CHAIRMAN SANTARE: Is there a second?

DR. GOODMAN: Second.

CHAIRMAN SANTARE: Is there further discussion?

DR. SCHAUWECKER: Could they come back with some additional information and figures at our meeting prior to October?

CHAIRMAN SANTARE: All in favor of the motion which is to proceed with the blueprints for the 16,000 sq. ft. expansion; also with the alternative that the 10,000 will be included in those blueprints and to have it let out for contractual bids and if possible to have it reported at the next Board meeting in August? All in favor of the motion, say aye.

The motion passed.

CHAIRMAN SANTARE: Now we have another tabled bit of business which is the Articles of Incorporation of the Indiana Medical Education and Developmental Information Center.

DR. PETRICH: I hope that you all have had an opportunity to read this and I would welcome any and all comments and criticisms and suggestions, change, etc. because I feel as Dr. Dukes, Dr. Santare, Dr. Wilhelmus do—that this is of paramount importance in relation to opposition to PSRO activities. I think we should do our own home work, which is the whole idea behind it.

DR. INGRAM: I have so many places that I have checked this, Peter, that I wonder if we have to go through an amendment in each form. We will be here all night. I wonder if it would be appropriate for those of us who have reviewed this to hand to you our comments on them and then discuss it again.

CHAIRMAN SANTARE: Dick, you are moving to table this until the next meeting and that any comments, criticisms, etc. from the Board of Trustees will be submitted to Dr. Petrich so that it can be resubmitted at the next meeting.

DR. SCHAUWECKER: Could I make one suggestion to Dr. Petrich? Get all these suggestions, make these changes, and mail it to us, at least one week ahead of the next meeting.

CHAIRMAN SANTARE: I would agree with that.

The motion to table was seconded and passed.

DR. FARQUHAR: I am under the impression that we are mandated by the House of Delegates to have a total separation of this corporation from the ISMA and I would seriously question, no disrespect intended, about Mr. Waggener's being named as the principal agent. I would feel that something would have to be spelled out to the Board of Directors of the one as separate from the Board of Trustees of the other, and I feel very strongly about this; I think there have been other similar comments made.

DR. SANTARE: I am going to call for new business.

DR. GOODMAN: Well, I don't know if this is old or new but I brought a matter with me that I thought this Board should consider briefly. I am turning to the Board for advice and assistance or at least a suggestion. On April 22, 1974, I got a form from the Medicaid Department, Government Claims Processing, 120 West Market St., Indianapolis, with some things checked off. They put in a couple of X marks and this concerns a claim that I had submitted for hospital care of a Medicaid recipient, and it says "Need admission and discharge summary." Now I did not know what our policy was at the state organization so I sent it up here hoping that it would get through some committee that would advise me and I don't know what happened to this. Now in the meantime, to further "muddy up the waters," on June 12, 1974, which was just a few days ago, I got a different kind of letter which is from the Medicare Department and it concerns a patient who was hospitalized rather extensively and said, "We need a copy of complete medical records on this patient." Now I wonder if this Board cares to instruct me either to comply with these things, not to comply with them, or not to render an opinion.

CHAIRMAN SANTARE: Dr. Goodman has brought up some new business. Is there a discussion?

DR. FARQUHAR: I have seen these. I would move that this Board instruct Dr. Goodman to ignore the paperwork that he is receiving, that we seek legal advice in order to find out feasibility of instituting a suit to get an injunction against intermediaries obtaining this type of information, and that we fight this all the way; stop this wholesale invasion of medical records in order to try to reduce expenditures in these governmental programs. I so move.

DR. SANTARE: Is there a second?

DR. INGRAM: I'll second that. I'd like to define a little of what we are going to sue them about, but I like the general concept.

DR. FARQUHAR: Sue them to stop this sort of thing, because it is going on and I brought it to your attention where a common clerk had vetoed my medical judgment.

The motion was put to a vote and passed.

Chairman Santare then requested the staff to get information on the suit possibilities utilizing Drs. Goodman's and Farquhar's specific information and report back to the August meeting of the Board.

The Board then adjourned to executive session.

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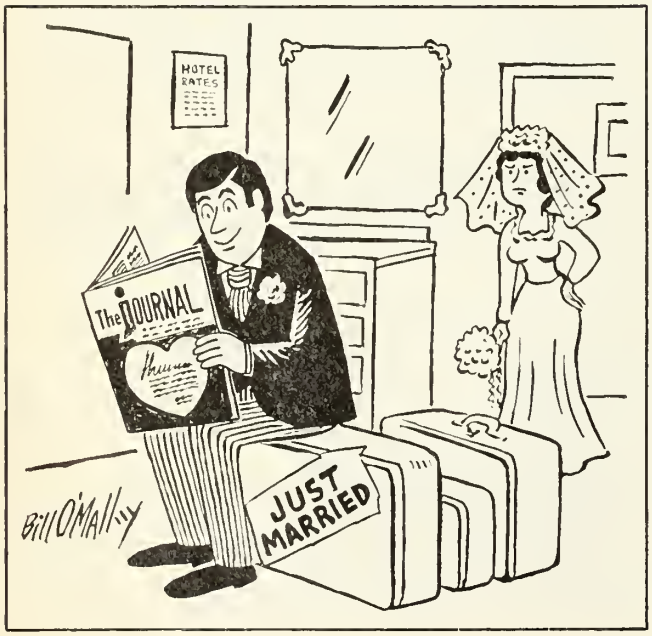
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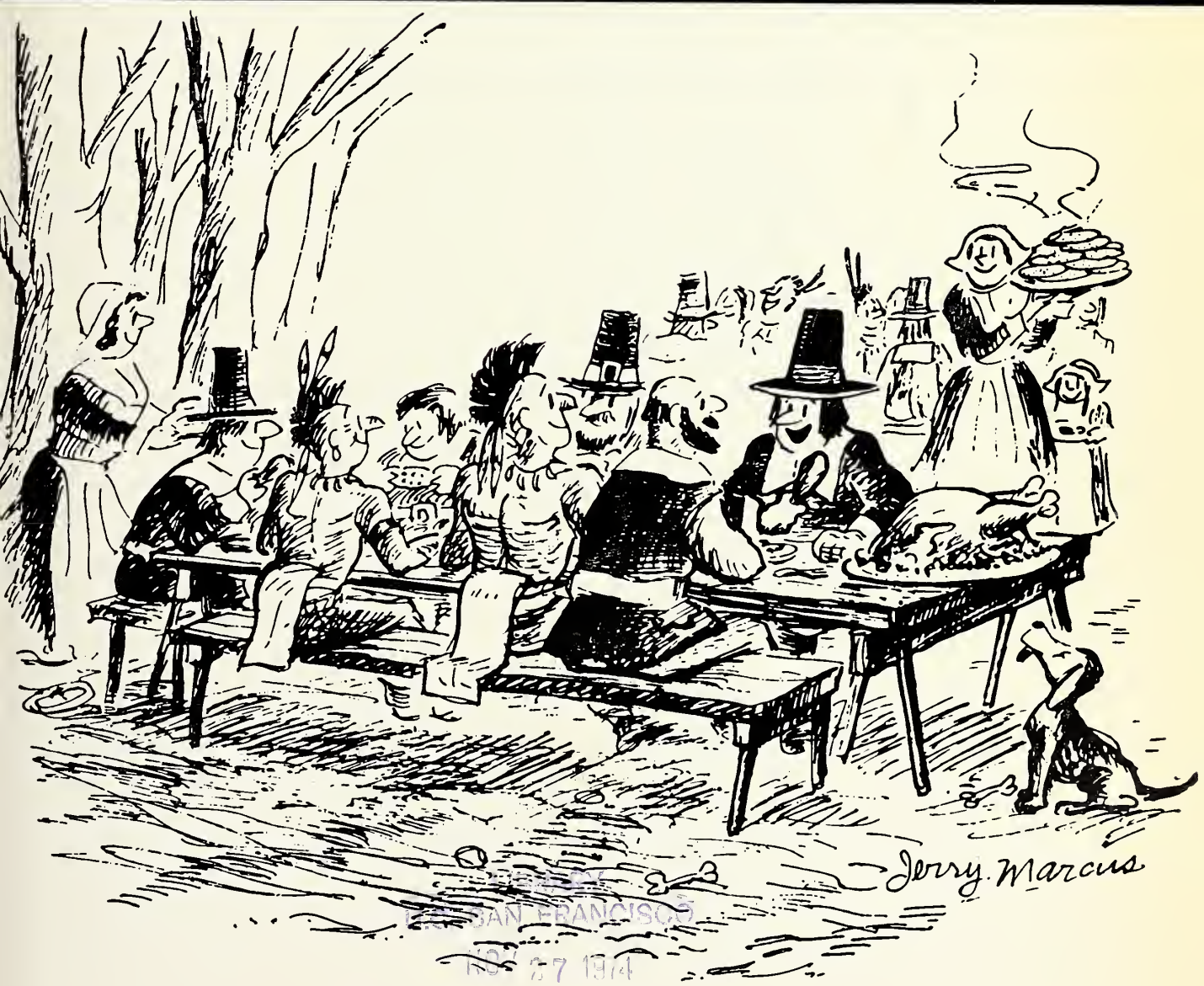
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1. Henry BW, *et al: Dis Nerv Syst 30*:675-679, Oct 1969.
2. Hollister LE, *et al: Arch Gen Psychiatry 24*:273-278, Mar 1971.
3. Claghorn J: *Psychosomatics 11*:438-441, Sept-Oct 1970.



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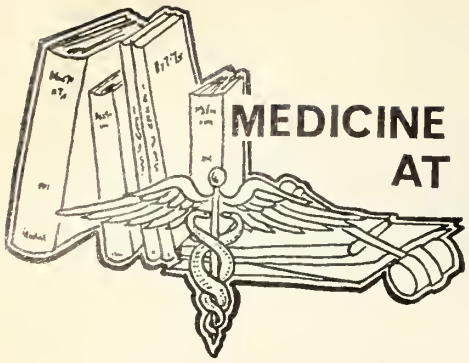
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MEDICINE AT LAW

Medical Clinic Has Duty to Take Reasonable Care of Parking Lot— A clinic's duty of reasonable care owed to patient-users of an outdoor parking lot was not diminished by the presence of natural accumulations of ice and snow, the Indiana Supreme Court ruled.

Snow fell on two separate days after the clinic parking lot had been plowed and salted. On the last day of the snowfall, a patient fell on the ice in the lot while returning to her car.

The patient sued the clinic, contending that it was negligent in failing to maintain the lot in a safe condition and failing to warn her that it was not safe. The trial court decided in favor of the clinic. The appellate court affirmed the trial court's decision.

The appellate court held that an owner was under no duty as a matter of law to remove natural (as opposed to unnatural) accumulations of snow and ice from a parking lot.

The supreme court found the appellate court decision to be "entirely inconsistent with the bedrock principles of occupier's liability." Holding that a landowner was under a duty to exercise reasonable care for the protection of invitees, the court found that the duty should not be diminished by the presence of natural accumulations of ice and snow. Reversing the judgment of the trial court, the supreme court sent the case back for further proceeding.—*Hammond v. Allegretti,* 311 N.E.2d 821 (Ind. Sup. Ct., June 6, 1974).

Rules of Court Limiting Contingent Fees in Negligence Cases Upheld—Rules adopted by the New Jersey Supreme Court limiting contingent fees in negligence cases were within the court's power to regulate the practice of law, a New Jersey appellate court ruled.

The New Jersey Supreme Court had specified the following limits on contingent fee arrangements in negligence cases:

(1) 50% on the first $1000 recovered;
(2) 40% on the next $2000 recovered;
(3) 33 1/3% on the next $47,000 recovered;
(4) 20% on the next $50,000 recovered;
(5) 10% on any amount recovered over $100,000; and
(6) 25% on the first $50,000 if the recovery is a settlement without trial for an infant or incompetent.

The rules provided that an attorney could obtain a court hearing to request a higher fee if the limitations resulted in an inadequate fee.

Attacking the validity of the contingent fee limitations, several lawyers' associations brought an action to declare the rules unconstitutional. The associations presented no evidence at the trial.

Recognizing that the problem of contingent fees in negligence litigation had been a concern to the state supreme court for about 15 years, the trial court nevertheless ruled that the fee limitations interfered with freedom of contract and unduly restricted attorneys' incomes. There was no information as to possible widespread abuse or complaints on which to base the court's conclusion that fees of 33 1/3% on recoveries above $50,000 were unreasonable, the trial court said.

On appeal by the lawyers, the appellate court stated that there was no merit to the associations' claims and reversed the decision of the trial court. The argument that the state supreme court lacked the power to issue the fee limitations was frivolous, the appellate court said. To accept that argument would be to invalidate similar rules regulating bar examinations, licensing of attorneys, creating a committee on the unauthorized practice of law, adopting canons of ethics, setting forth limitations on the practice of law by attorneys in public office, requiring separate business and client bank accounts and bookkeeping records, and providing a client's security fund.

The state constitution clearly gave the supreme court the exclusive power to regulate the practice of law, the appellate court said. The delegated authority included the power to adopt reasonable rules establishing the outer limits of permissible contingent fees in tort litigation.

Even if the court could adopt such a rule, a hearing was required to issue a valid rule, the associations contended. The Supreme Court was exercising the power vested in it as one of the three branches of government, the appellate court said. Its action was legislative in nature, and no hearing or finding of fact was required.

The court's rule was presumed to be reasonable, and the associations did not present any evidence to rebut that presumption. Therefore, the trial court's ruling was erroneous.

As to the claim that the fee limitations violated freedom of contract, the appellate court said that attorneys have never had the right to enforce contracts for more than a fair and reasonable fee. Membership in the bar was a privilege burdened with the conditions imposed by the court and derived from an

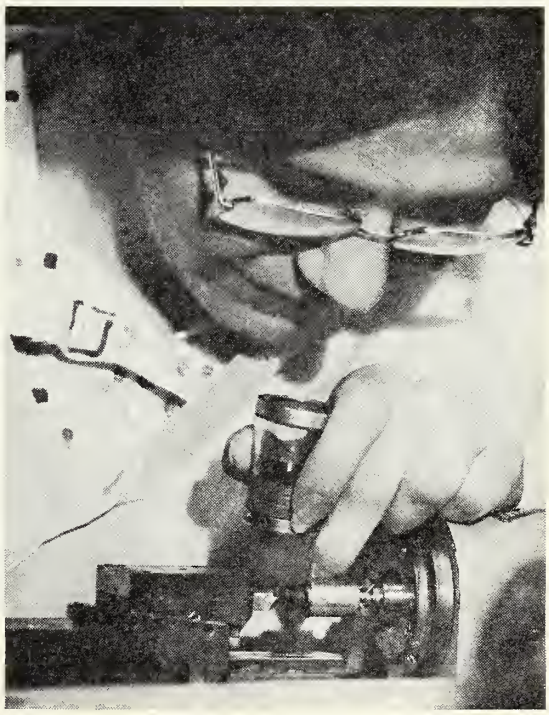
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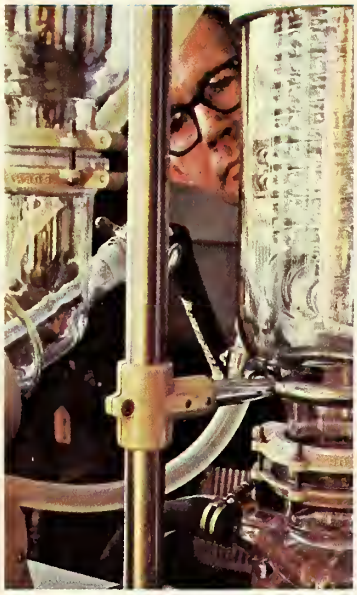
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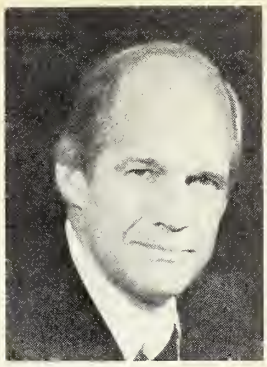
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President's Page



One of the leading priorities for the Indiana State Medical Association Leadership in the coming months is the medical liability problem. This problem is twofold: increased number of malpractice suits and their amounts, and the inability of doctors to obtain medical liability insurance.

The cost of malpractice is increasing yearly. Not only the obvious cost of time, effort and money, but also the terrible cost of reputation and the erosion of trust and faith in the physician—and we all know so many of the claims are baseless, foundless, illogical, yet still damaging. It is because of this that the leadership feels the whole basis of difficulties in medical liability insurance originated.

A committee has been appointed to represent a broad aspect of the medical force in this state. From this committee, multiple task force groups are being formed, i.e.—insurance, legal, economic, consumers, unions, etc. At the first meeting of this committee all avenues of the medical liability problem were discussed. We are studying the various arbitration plans, compulsory and non-compulsory, the pros and cons of the various screening plans and advisability of seeking ways and means of limiting amounts of recoveries. It is apparent that legislation is probably the answer to our problem. The Indiana State Medical Association is making a determined effort to secure new insurance sources. Any physician who is having difficulty in obtaining medical liability insurance, please notify us at the State Association. We can then tabulate the difficulty, and also assist you and inform you where medical liability insurance may be obtained.

The following is the risk classifications that most insurance companies use to classify doctors for medical liability.

CLASS I
Allergists
Dermatologists
Hemotologists
Internists
Pathologists
Pediatricians
Radiologists
Psychiatrists

CLASS II
General Practitioners
(doing minor surgery)

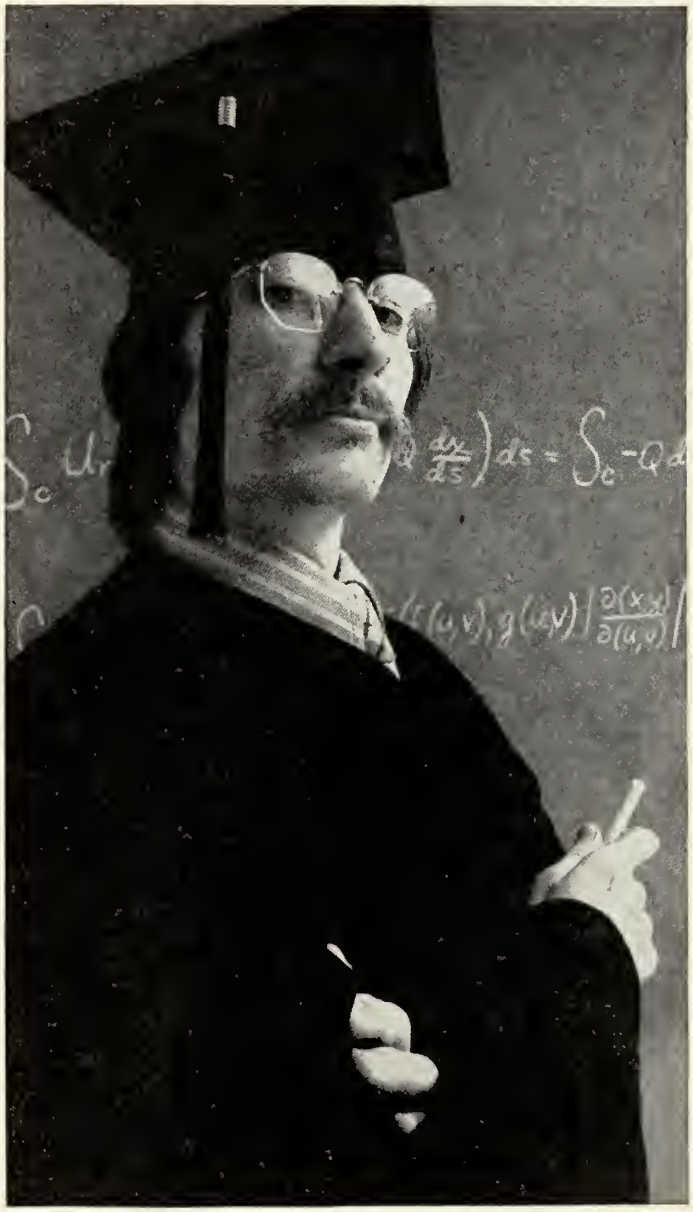
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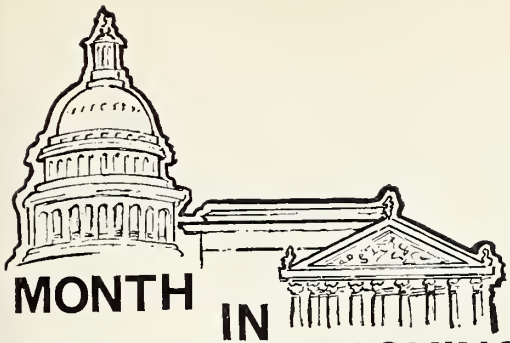
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MONTH IN WASHINGTON

This summary of what is happening in Washington is prepared by AMA's Capitol office and air-mailed to The Journal on the first of each month preceding month of issue.

The Senate has overwhelmingly passed legislation that would require one fourth of all medical and dental school graduates to spend at least two years in the nation's slums and rural areas where there are shortages of physicians.

Earlier the Senate voted down a much more sweeping bill sponsored by Senator Edward Kennedy that would have required mandatory federal service for all health professions students and national licensure and relicensure for physicians and dentists.

Hours before the first Senate vote Senator Kennedy, aware that he was losing liberal support, shelved his Health Subcommittee's $5.1 billion, five-year bill and offered a substitute measure which was trounced 57-34. Instead the Senate adopted a measure sponsored by Senator J. Glenn Beall, Jr., (R-Md.) and went on to pass a three year, $2 billion health manpower bill by a vote of 81-7.

The bill finally approved by the Senate was stripped of most of the controversial provisions of the original Kennedy bill and was a victory for the American Medical Association, the American Dental Association, and the Association of American Medical Colleges.

The Senate bill calls for a three-year extension of present federal programs for aiding medical education at a total cost of about $2 billion. Capitation grants for medical schools would be continued at a high level despite the administration's request for a cutback.

The Beall substitute measure provides federal aid to medical and dental schools that agree to allocate 25% of their classroom space to students volunteering to serve in areas short of medical care workers. In return for either civilian or federal service under the National Health Service Corps, the students would receive scholarships.

The Kennedy bill would have compelled all medical school graduates to serve in the shortage areas, an approach labelled a "domestic draft" by Senator Beall and his committee colleagues, Senators Peter Dominick (R-Colo.) and Robert Taft, Jr. (R-Ohio), who developed the substitute measure.

The Senate bill does not contain the original requirement for a federally appointed National Council on Postgraduate Education with 10 regional councils designed to deal with allocation of speciality training slots and foreign medical graduates. The Senators contended this was too heavy an involvement of the federal government.

Another casualty of the Senate voting was the proposal for federal standards for licensing and relicensing physicians and dentists, a plan that stirred wide protest within the professions.

The Maryland Senator's bill represented a middle ground on financial help for medical schools, with the AAMC contending the amount was too low and the Administration believing it was too high.

Immigration standards would be tightened to restrict the number of foreign medical graduates under the Senate bill.

House Bill Differs from Senate Bill

On the other side of the Capitol, a House subcommittee has approved a counterpart bill to the Senate manpower legislation that would establish federal scholarships intended to increase the number of doctors in the nation's rural areas and urban slums where there are doctor shortages.

The House subcommittee's bill authorizes $240 million over three years for National Health Service Scholarships paying $9,200 to $9,500 a year to cover the cost of a medical education.

In return, the scholarship recipients would have to spend two to four years serving in areas with doctor shortages. Non-scholarship students who volunteer to practice in areas with doctor shortages would receive a guaranteed income of $28,000 a year until they get their practices started.

The bill would also give medical schools a grant of $2,100 a year for each student—$400 less than the schools now receive.

But any graduate who does not practice in an underserved area would have to repay the government the money given to the medical school.

Though the House bill differs sharply from the Senate version, particularly the Senate provision forcing medical schools to have one fourth of their classes on federal scholarships requiring two years of practice in

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12.	J. Robert Edwards, Auburn	Thomas A. Felger	Sept. 11, 1975
13.	John O. Hildebrand, Jr., South Bend	David L. Spalding, Mishawaka	South Bend

underserved areas, the House subcommittee chairman, Paul G. Rogers, (D-Fla.), believes the difference can be resolved when the two bills go to conference.

Long-Ribicoff Bill's Chances "Extraordinarily Slim"

Undaunted by collapse of the National Health Insurance (NHI) measure in the House Ways and Means Committee in late summer, Senator Russell Long, (D-La.) is forging ahead with plans to ram a bill through the Senate in the strained atmosphere of a "lame duck" Congress. Long is Chairman of the Senate Finance Committee and sponsor along with Senator Abraham Ribicoff, (D-Conn.) of a NHI plan featuring a Social Security financed and operated catastrophic health insurance plan for all. The Long-Ribicoff bill enjoys the official support already of 25 senators and rates some chance of Senate passage.

But the chances of passage of a version of such a Senate bill by the House in a "lame duck" session after the November elections is considered extraordinarily slim.

Little Talk About Health Care Costs and Inflation at Summit Economics Conference

President Ford's long-heralded summit economic conference produced relatively little talk about health care costs and inflation, despite the fact that HEW Secretary Weinberger has of late frequently sounded such an alarm.

Nor was there any indication during the Washington parley that the Administration was considering controls at this time, although Senate Majority Leader Mike Mansfield, (D-Mont.) urged the 800 delegates to request such controls.

However, it became clear to conference observers that the President will ask Congress to approve certain but unspecified tax changes and to cut the federal budget to combat inflation.

American Medical Association President Malcolm C. Todd, a delegate to the summit conference, said that he agreed with the President with respect to avoiding controls at this time—"particularly discriminatory cost controls."

"Every American, every physician, has the duty to assist in solving the number one problem of the nation—inflation," Dr. Todd said, noting that the AMA has repeatedly stressed the need for restraint by physicians in avoiding unjustifiable charges and fee increases.

A summary of the earlier pre-summit session on health was presented by Michael Zubkoff, Professor of Health Economics at Meharry Medical College and Vanderbilt University. He stated that "it is generally recognized that the health sector is both a hostage and a cause of inflation."

According to Professor Zubkoff, the pre-summit meeting had determined certain "structural defects" in the health care delivery system which included.

"Fee-for-service payment for physicians and cost-plus reimbursement for hospitals . . . encourages cost growth.

"First-dollar insurance coverage reduces cost-consciousness by consumers.

"Consumers lack knowledge to become aggressive, informed purchasers of health care."

Among the "common themes" stressed at the pre-summit health conference, Zubkoff said, were that the federal commitment to health care should not be reduced, that structural reform is needed, and that existing incentives and regulatory mechanisms are inadequate.

"There was a definite lack of a widespread consensus on soultions to cost problems in health during the pre-summit meeting," Zubkoff told the summit meeting.

While pleased that President Ford had not called for wage-price clamps by the federal government, Dr. Todd at the same time criticized the Administration for "singling out" health by "annualizing" monthly consumer price index levels. The practice of projecting the yearly increase on the basis of what happens during one month or several months has been followed only on "health" by the HEW Department so as to bolster its contention that the health segment should be isolated for controls, Dr. Todd charged.

The AMA President noted that in the past three years physicians' fees have risen 17.6% compared with 22.9% for the economy as a whole and, for example, 32.9% for legal charges.

Suggested steps to curb medical costs, listed by Dr. Todd, were pre-admission testing, expansion of ambulatory care services, earlier discharge from hospitals, avoidence of unnecessary hospitalization, reducing wasteful testing, prescribing and treatment, and decreasing the cost of malpractice insurance.

In addition, Dr. Todd said, there must be incentives to produce more family physicians and to plan for needed specialists only.

"Perhaps physicians should attempt voluntarily to guide their fee-setting decisions by tying their charges to the consumer price index levels and not exceeding them," Dr. Todd suggested.

AMA Delegation Confers with Secretary Weinberger

A wide range of health care related subjects was discussed at a recent meeting between an AMA delegation and Health, Education, and Welfare Secretary Caspar Weinberger.

Malcolm Todd, M.D., President of the AMA, said the Secretary and his aides were told that the AMA desires the best possible national health insurance (NHI) program that can be worked out, but cautioned

Continued

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against any hurry-up approval in an emotionally charged Congress late in the session.

Dr. Todd said he emphasized that the number one problem facing the nation at present is inflation and that therefore any NHI program should have a minimal impact on this problem. AMA officials urged that NHI be kept outside of the Social Security Administration.

The AMA delegation urged that controls not be re-imposed on the medical profession, citing the AMA's urging of moderation by physicians to keep fees in line with expenses.

Other subjects at the meeting included manpower legislation and current procedural terminology.

The AMA delegation included, in addition to Dr. Todd, Richard Palmer, M.D., chairman of the AMA board of trustees; Russell Roth, M.D., past president; William Holden, M.D., board member; Ernest Livingstone, M.D., chairman of the Council on Legislation; James Sammons, M.D., executive vice president designate; Joe Miller, deputy executive vice president; Whalen Strobhar, assistant executive vice president; and Harry Peterson, director of the legislative department.

British See Link Between Breast Cancer and Reserpin

The Food and Drug Administration is planning a letter to physicians alerting them to a series of studies to be published in *Lancet,* the British Medical Journal, that finds a higher-than-normal incidence of cancer of the breast among women age 60 and older who have been treated with Reserpin for high blood pressure. A panel of experts appointed by the HEW Department will review the data.

FDA May Require Warning Labels On Some Oral Diabetic Preparations

The Food and Drug Administration has indicated to Congress it will order warning labels placed on some oral diabetic preparations when a new study of the drugs' safety and efficiency is published soon.

Alexander Schmidt, M.D., FDA Commissioner, told the Senate Monopoly Subcommittee headed by Senator Gaylord Nelson that the FDA endorses a 1970 study by the University Group Diabetes Program which found that the drugs (tolbutamide and phenformin) were linked with a heart disease death rate twice as high as for diabetics taking insulin or no drug at all through diet.

Within a few weeks, an 18-month audit of the 1970 study is due to be published and apparently it backs up the major findings of previous study. The audit is being prepared by a special panel of the Biometrics Society.

Law suits challenging the FDA's right to impose warning labels have deterred the agency from action to date, Dr. Schmidt told the Subcommittee. He said many physicians have something close to a "religious belief" that the oral diabetic preparations by lowering blood sugar decrease the likelihood of cardiovascular complications among diabetics.

Major opponent of relabeling is the Committee on the Care of the Diabetic, composed of some 180 physicians. The issue has proved a serious controversy among specialists in the treatment of diabetics, with experts taking both sides.

The FDA is relying on the audit to strengthen its hand sufficiently in the legal fight to allow it to go ahead with warning labels, but the prospects are that the actual implementation of such an order will be tied up in the courts for some time. ◄

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attorney's position as an officer of the court.

That contingent fees were singled out from among the varieties of fee arrangements did not violate the right of equal protection, said the appellate court. There was a reasonable basis for separating contingent fees from others, the court said. Contingent fee arrangements involved unique problems in the attorney-client relationship, including those arising from that method of compensation which bore no direct relationship to the effort expended by the attorney or the value of his services.

Finally, there was no merit in the associations' contention that the rules impaired existing obligations. Attorneys who thought they would be unfairly harmed could seek court approval of a higher fee than the one permitted by the rules, the appellate court concluded.

It was clear that the rules limiting contingent fees were valid and constitutional, the appellate court said as it reversed the trial court's decision.—*American Trial Lawyers Association, New Jersey Branch v. New Jersey Supreme Court,* 316 A.2d 19 (N.J.Super.Ct.,App.Div., Feb. 14, 1974)

Editor's Note: Medical malpractice suits are included in the category of negligence cases, in which claimants are almost invariably represented on a "contingent fee" basis.

Suit for Birth Injuries allowed Two Years After Child Comes of Age— A medical malpractice suit based on injuries received during childbirth was properly filed within two years after the child reached the age of majority, the Indiana Supreme Court ruled.

During delivery the attending physician had used forceps on both sides of the child's head. Because of his alleged negligence, the optic nerve controlling the child's right eye was severely damaged, resulting in almost complete loss of sight in his right eye.

Twenty-two years later the child, now an adult, brought a malpractice action against the physician. A trial court sustained the physician's contention that the claim was barred by the two-year statute of limitations. An appellate court affirmed dismissal of the case.

On appeal to the Supreme Court, the malpractice statute limiting actions to those filed within two years of the allegedly negligent conduct was challenged as unconstitutional. It gave special privileges and immunities to the medical professions, the injured child argued.

There is a reasonable basis for distinguishing between those giving medical services and those who do not, the court said. Therefore the malpractice limitation statute was held to be valid.

However, the trial court had ruled that another Indiana statute, which provided that minors could bring lawsuits within two years after they became adults, did not apply in this case. Since it was inconsistent with the newer malpractice statute, the newer law controlled, the trial court had said.

The state Supreme Court did not agree with this interpretation. The two statutes are not inconsistent, the court said, because the statute permitting a minor to bring an action after he became an adult did not come into play until the malpractice statute had run. The appellate court's decision limiting suits to those brought within two years of the negligent conduct was unduly harsh, because in some cases the results of malpractice on a minor child remain undiscovered for many years, the court said.

Concluding that the suit had been brought within the time permitted by statute, the Indiana Supreme Court remanded the case for further proceedings.—*Chaffin v. Nicosia,* 310 N.E.2d 867 (Ind.Sup.Ct., May 14, 1974).

Editor's Note: A prior decision in this case was reported in *JISMA,* Mar. 1974, Vol. 67, No. 3, p. 208.



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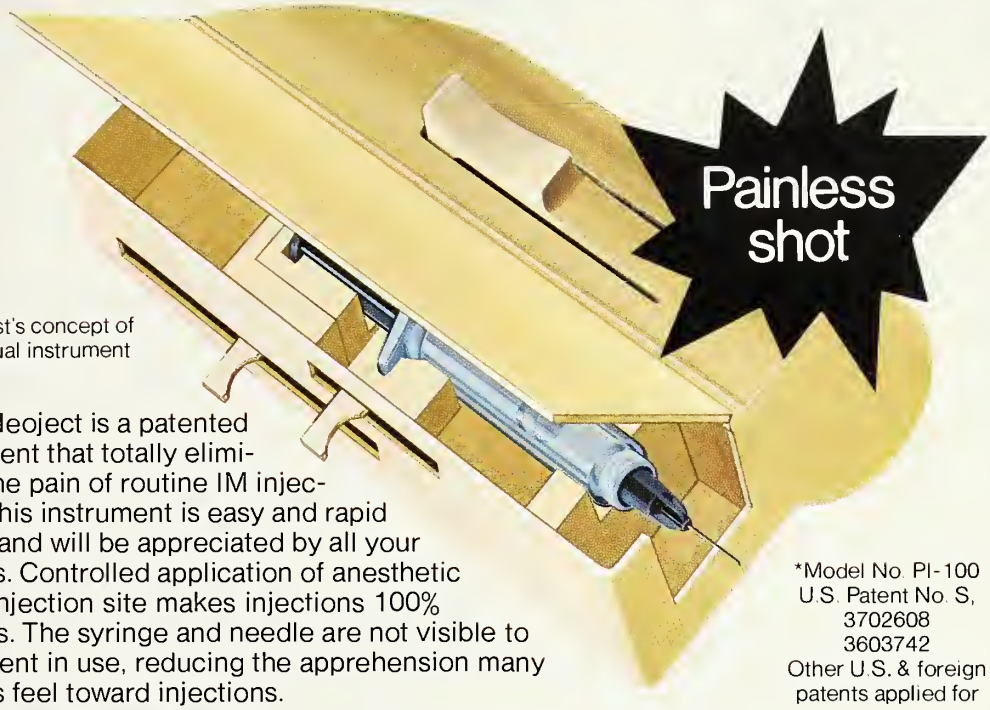
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The Journal of the INDIANA STATE MEDICAL ASSOCIATION

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A new approach to the treatment of metastatic malignant disease is presented.

Cancer Immunotherapy

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THE treatment of cancer by immunotherapy has become accepted in view of the hopelessness of terminal cases and the lack of further response to the other modalities available to us, particularly chemotherapy and radiation therapy in combination or separately. Immunotherapy has evolved through multiple observations in this country and in Europe of tumor patients immunized against *M. tuberculosis* as compared to those without immunization.

The selection of patients receiving immunotherapy depends primarily on the location of the tumor and accessibility to treatment. Therefore, most tumors so treated at present are skin neoplasms, particularly melanoma, head tumors and neck tumors. Certain investigators have concentrated primarily on tumors of experimental animals, using immunotherapy (BCG) injected directly into tumors, intravenous injection for pulmonary dissemination and hepatic artery infusion for hepatic spread. Their results remain to be reported and evaluated.

Before patients are selected for treatment, a complete diagnostic workup is required, including liver profile, blood count and chest x-ray. Skin tumors are easily accessible and are a model system for such a therapeutic study. In order to exclude patients with disseminated disease and altered immunity, it is required that they be selected with existent disease and intact immunity, including determination of hypersensitivity. Since the main action of BCG is a non-specific stimulation of delayed hypersensitivity, any immunologic maneuver is contraindicated in the presence of anergy. The majority of investigators at the present time believe in the immunologic surveillance theory of Burnett and the control of existing tumors by an intact delayed hypersensitivity mechanism.[2,4,8,10] Patients, therefore, who are anergic (i.e., unable to react against foreign antigenic stimulation) should be excluded from such treatment since the injection of BCG may then act to disseminate tuberculosis, as has been reported.[1,17]

Delayed hypersensitivity and reactivity of the patient is determined by means of topical application of dinitrochlorbenzene (DNCB), a hapten that induces a chemical delayed hypersensitivity when combined with skin proteins. The present mode of DNCB testing has been perfected by Catalona and Chrietien at the National Institute of Health.[2] Two concentrations of DNCB (2,000 μg and 50 μg) are applied to specific areas of the forearm which measure 3 cm square. The amount of solution applied to each site is 0.1 cc. Reactivity must be checked sequentially at one, two, three, four, and fourteen days after the initial application. The reactivity that appears first is for the higher concentration of DNCB and is a combination of delayed reactivity and sensitization to the drug. Later reaction to the lower concentration (50 μg) is primarily a delayed hypersensitivity type of reaction. In anergic patients who fail to show reactivity to either of these concentrations it is advisable to retest one to two weeks later with 50 μg on the other arm to evaluate reactivity from a previous stimulation to DNCB. If they remain anergic, they should be excluded from further consideration of immunotherapy.

It is also advisable to use the standard PPD, mumps, candida, and

histoplasmin skin tests to determine prior exposure to those antigens and to supplement the evaluation of any skin reactivity and of the biologic competence of any delayed hypersensitivity.

The treatment is accomplished by injection of BCG (Bacillus Calmette-Guerin), an attenuated tuberculosis bacillus produced by several sources. Injection may be intralesional or paralesional and the mode of treatment is as follows: Daily intralesional injection with .1 cc per day per lesion is continued until a reaction is elicited which includes erythema, edema and decrease in the size of the lesion.[10,11,-14,15] Frequency of injection is then decreased to variable intervals of two to seven days. If reaction is not detected within 21 days, tumor response is not likely.

Immunotherapy appears to be simple but requires a knowledge of the cutaneous reactivity of the patient toward antigens eliciting humoral and/or delayed hypersensitivity. As noted earlier, an anergic patient may be harmed by such therapy. Close follow-up is mandatory to ensure prompt treatment of complications.[11,12]

Since this form of treatment remains investigative, it should be fully explained to the patient. Immunotherapy programs are being carried out in various centers in this country, some of which are associated with the National Cancer Institute, Bethesda, Md. We are currently establishing a clinical research program in this regard in collaboration with the National Institute of Health and National Cancer Institute and hope to have valid data pertaining to the immunotherapy of accessible metastatic cancer within three to five years.

REFERENCES

1. Blumire, - A2 - BCG: A note of caution. *N. Engl. J. Med.* 289:869, 1973.
2. Catalona, W.J., Chrietien, P.B.: Abnormalities of quantitative DNCB sensitization in cancer patients. *Cancer* 31:353, 1973.
3. Eagan, R.T., Sparks, F.C., Morton, D.L.: Cancer Immunotherapy. *Ann. Int. Med.* 78:153, Jan. 1973.
4. Eilber, F.R., Morton, D.L.: Impaired immunologic reactivity and recurrence following cancer surgery. *Cancer* 25:362, 1970.
5. Eilber, F.R., Morton, D.L.: Cutaneous anergy and prognosis following cancer surgery. *Surg. Forum* 20:116, 1969.
6. Fefer, A.: Immunotherapy of cancer. *J. Natl. Cancer Inst.* 47:VIIX, 1971.
7. Greentree, L.B.: Cancer and tuberculosis. *Am. J. Obstet. Gynecol.* 106: 1098, 1970.
8. Ikonopisove, R.L.: The rationale of immunostimulation procedure in the therapeutic approach to malignant melanoma of the skin. *Tumors* 58: 121, 1973.
9. Makie, G.: Immunological treatment of leukemias. *Br. Med. J.* 4:487, 1971.
10. Morton, D.L.: Cancer immunology and the surgeon. *Surgery* 67:396, 1970.
11. Morton, D.L.: Immunotherapy of cancer, present status and future potential. *Cancer* 30:1647, 1972.
12. Morton, D.L., Eilber, F.R., Malmgren, R.A., et al.: Immunological factors which influence response to immunotherapy in malignant melanoma. *Surgery* 68:158, 1970.
13. Oettgen, H.F., Old, L.J., Boyse, E.A.: Human tumor immunology. *Med. Clin. North Am.* 55:761, 1971.
14. Seigler, H.F., Shingleton, W.W., Metzgar, R.S., et al.: Non-specific and specific immunotherapy in patients with melanoma. *Surgery* 72: 162, July 1972.
15. Zbar, B., Tanaka, T.: Immunotherapy of cancer regression of tumors after intralesional injection of living mycobacterium bovis. *Science* 172: 271, 1971.
16. Zbar B., Bernestine, I.D., Bartlett, G.L., et al.: Immunotherapy of cancer: regression of intradermal tumors and prevention of growth of lymph node metastasis after intralesional injection of living mycobacterium bovis. *J. Natl. Cancer Inst.* 49:119, July 1972.
17. Sparks, F.C., Silverstien, M.J., Hunt, J.S., et al.: Complications of BCG immunotherapy in patients with cancer. *N. Engl. J. Med.* 289:827, 1973.

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Sickle Cell Leg Ulceration— A Non-Operative Outpatient Method of Management

LUCY S. WARD, M.D.
WILLIAM M. DUGAN, JR., M.D.
Indianapolis

LEG ulcerations in patients with sickle cell anemia are a frustrating medical problem. These ulcerations are "not entirely due to the presence of Hgb. S. (4)." They are also the results of chronic hypoxia with poor circulation, edema, trauma and infection. The following method of management is similar to that for common stasis ulcers.

1. *Rest*—Although bed rest is rarely possible, it is the most useful form of treatment. Frequent rest periods during the day are especially useful.

2. *Elevation*—The leg should be elevated 30° when in bed and elevated comfortably whenever sitting.

3. *Cleansing and Debridement*—Regular daily cleansing with soap and warm water is adequate. However, in more severe cases with exudates, aluminum acetate (Domeboro tablets) soaks applied for 15 minutes three times a day are useful.

4. *Elastic Stockings*—ALL patients with even minimal ulceration should wear well-fitting elastic stockings. To maintain their effectiveness they must be replaced at least four times a year.

Medications—

a) Hydrocortisone cream 1% will reduce itching and inflammation.

b) Topical antibiotics should be used in the presence of local infection. However, the skin around an ulcer is easily sensitized and topical antibiotics should be used sparingly. (Garamycin is rumored to be less sensitizing than triple antibiotics preparations.)

c) Systemic antibiotics should be used for systemic infection after an adequate culture is obtained.

6. *Unna's Boot*—can be used in the presence of severe or persistent ulceration.

a) Clean area to be covered with soap and water.

b) Apply Elase directly to ulcer if further debridement is necessary.

c) Elevate leg approximately one half hour to reduce edema.

d) Apply medicated paste bandage directly to skin from base of toes to above ulcer as smoothly as possible.

e) Allow to dry several minutes.

f) Cover with elastic bandage.

g) Change every week or as necessary. Large Lister bandage scissors may be used to remove the boot. Initial changes may be made every three to four days, whereas later every two to three weeks may be often enough, depending on the condition of the boot.

h) Warn the patient that he may have some pain initially but it should be mild and decrease with further wearing.

i) Continue applying new boots until complete healing occurs.

No treatment will permanently cure sickle cell leg ulcers. However, proper treatment will result in considerable improvement with long-term healing.

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BIBLIOGRAPHY

1. Pillsbury, Donald: *Dermatology*, W.B. Saunders Co., 1956, pp. 414-421.
2. Maddin, Stuart, ed.: *Current Dermatologic Management*, C.V. Mosby Co., 1970, p. 85.
3. Stewart, William: *Synopsis of Dermatology*, C.V. Mosby Co., 1970, p. 421.
4. Williams, W.J., et al.: *Hematology*, McGraw-Hill Book Co., 1972, p. 417.
5. Wolfort, Francis; Kriget, Thomas: *Plastic and Reconstructive Surgery*, Vol. 43, No. 1, "Skin ulceration in sickle cell anemia." 1969, pp. 71-77.◄

This paper was written while Dr. Ward was on a senior hematology elective at Methodist Hospital Graduate Medical Center. She is now a straight medical intern at Mount Sinai Hospital, Milwaukee, Wis.

Fetus-in-Fetu

DONALD C. PARKER, M.D.
Fort Myers, Fla.

In the diagnosis of abdominal masses and calcifications many unusual entities are noted. Of these, one of the most unusual involves the following case.

Case Report

C.K., a six-week-old male, was brought to Riley Children's Hospital on Dec. 20, 1972, after his mother discovered that he had an abdominal mass. The patient had been previously asymptomatic. Physical examination revealed that the patient had a large epigastric abdominal mass.

On x-ray examination a large abdominal mass was noted with calcification (Fig. 1,2). Also noted was a well-developed vertebral column with other differentiations such as limb buds, bones, and striking similarities to a skull and pelvis. The mass was excised, and the patient has subsequently done well.

Discussion

This configuration has been referred to as "included twin," "parasitic twin," and "fetus-in-fetu." There is a lingering association, however, with the major differential diagnosis of teratoma when the first two terms are used.[4] The condition is defined as a vertebral fetus included within its partner, with the former also being referred to as the parasite and the latter the host (Fig. 3).[5] Most commonly, fetus-in-fetu has been discovered to be in the retroperitoneal space.

A teratoma is defined as a true tumor or neoplasm composed of multiple tissues foreign to the part in which it arises.[6] It can be either benign or malignant. Since no fully documented case of fetus-in-fetu has ever demonstrated metastases, it can be seen that this represents a condition that differs from retroperitoneal teratoma.

Lord,[5] in 1956, found 31 reports of alleged fetus-in-fetu before 1900 and 11 reported since that year. She noted that all of the cases of proven fetus-in-fetu were in the

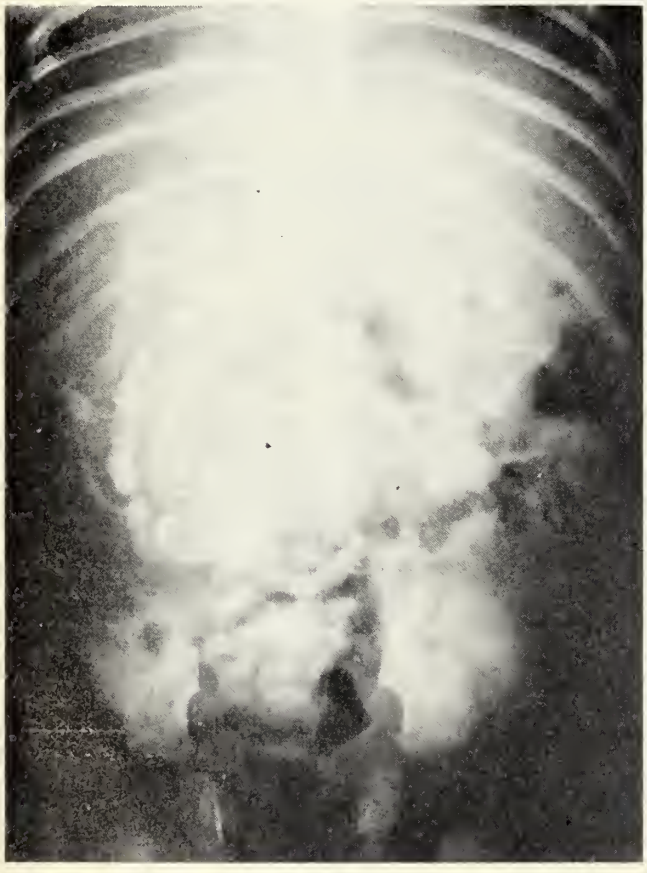


Figure 1. Note the well-developed spine.



Figure 2. A well-formed cranium anterior to spine.



Figure 3. Parasite removed.

upper part of the abdominal retroperitoneal space, and that none had a distinct umbilical cord, but instead possessed a pedicle directed toward the superior mesenteric artery and vitelline circulation. Subsequently, it was postulated that this may be the result of incorporation of the parasite at some stage of fetal development and the close association of superior mesenteric artery and vitelline circulation.

It should be mentioned that the incorporated fetus would have to be a diamniotic, monochorionic, monozygotic twin of its bearer, included during development due to anastomosis of the vitelline circulation.[1,5] One of the other explanations of these anomalies attributes them to abortive parthenogenesis.[3] This theory implies a spontaneous development of ova or sperm cells without fertilization.

The parasite does not represent a surgical emergency.[2] However, it should be removed because of the danger of infection, infarction or obstruction.[4] The mass may be removed *in toto,* or the sac may be evacuated and left *in situ.*

In summary, an unusual case of an abdominal mass with well-developed skeletal structures including a well-developed vertebral column has been discussed. Also it has been demonstrated that there are differences between this mass and retroperitoneal teratomas. There have been at least 15 fully documented cases of fetus-in-fetu since 1900 with no evidence of metastases. The etiology is still unclear. However, these masses should be removed due to the risk of infection, infarction or obstruction.

REFERENCES

1. Arey, L.B.: *Developmental Anatomy,* Ed. 4, Philadelphia, 1972, W.B. Saunders Company, pp. 167-182.
2. Broghammer, B.J.: The Included Twin or Fetus in Fetu, *Amer. J. Radiology Radium Ther.* May 1963, pp. 844-846.
3. Kakizoe, T.: Fetus in Fetu Located in the Scrotal Sac of a Newborn Infant: A Case Report., *J. Urol.* 107:506-508, March 1972.
4. Lewis, R.H.: Fetus in Fetu and the Retroperitoneal Teratoma, *Arch. Dis. Childhood,* 36:220-226, April 1961.
5. Lord, J.M.: Intra-abdominal Fetus in Fetu, *J. Path. and Bact.* 72:627-641, October 1956.
6. Willis, R.A.: *Pathology of Tumors,* St. Louis, Mo., C.V. Mosby Co., 1948, p. 941. ◄

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Recent Developments in Treatment of Childhood Cancer—II

ARNOLD J. ALTMAN, M.D.
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Indianapolis

Hodgkin's Disease

Hodgkin's Disease is the most common lymphoma in the pediatric age group and is a neoplastic disease in which great advances in therapy have been made in the past decade, resulting in an increasingly optimistic outlook for such patients. Prognosis, however, is still dependent on two major factors: histologic character of the tumor and stage of disease at the time of diagnosis.

Hodgkin's Disease is currently classified under four histologic types: 1) lymphocyte predominance, 2) nodular sclerosis, 3) mixed cellularity, and 4) lymphocyte depletion. Types 1 and 2 have the best prognosis while type 4 frequently runs a fulminant, unresponsive course.

Hodgkin's Disease is now staged according to the Stanford classification.[8] In most centers staging involves complete physical examination, chest x-ray, IVP, inferior vena cava gram, lymphangiogram, splenectomy, liver biopsy, and biopsy of selected abdominal nodes. Prognosis is clearly related to extent of disease at the time of diagnosis. As shown in Table II, Stage I (involvement of a single lymph node region) has an estimated five-year survival of over 80%, while Stage IV (multiple or disseminated foci) has only a 35% five-year survival. Stages II and III, which involve intermediate degrees of involvement, have an estimated five-year survival of 70% and 50% respectively.[9]

Radiotherapy is the major mode of treatment for Stages I-IIIA. It is important to deliver an optimal dose (3,500-4,000 rads at 1,000 rads/week) in order to permanently eradicate any given site of involvement; smaller doses, although temporarily resulting in regression of enlarged nodes, are frequently followed by local recurrences. For Stages IIIB and IV, combination chemotherapy (the so-called MOPP therapy of DeVita[10]) is used. This regimen has resulted in suppression of Hodgkin's Disease in 70-80% of previously untreated patients and produced complete remission in 35% of Stages III and IV patients.

Neuroblastoma

Next to brain tumors neuroblastoma is considered to be the most common solid tumor in childhood. As seen in Table III, prognosis in this condition depends primarily on age and extent of disease at the time of diagnosis; other factors which also influence survival are site of primary tumor and degree of differentiation of tumor. An important recent development is recognition of a special category of patients with metastases to subcutaneous tissue, bone marrow or liver who may still have an excellent prognosis even without treatment, especially if they are under one year of age—such patients are classified at Stage IVs.[12] By contrast, once bone cortex is involved the prognosis is extremely grave and prolonged survival is rare. Overall, the outlook for neuroblastoma patients is still not good, with less than one-third surviving for two years or more; the major factor influencing this poor prognosis is probably the fact

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Supported by grants from the Riley Memorial Association (#73-1, #22-860-02) and Children's Cancer Study Group A (#50-860-14).

Part I of this article, concerning the role of the primary physician and of the cancer center in care of the child with a malignancy and dealing with Acute Lymphocytic Leukemia, appeared in the October *Journal*, pp. 925-927.

that 70% of such patients already have metastases at the time of diagnosis.[13]

Among the unique features of neuroblastoma are:

1) The production of specific metabolites (catecholamines, vanillyl mandelic acid, homo-vanillic acid, metanephrine) which are excreted in the urine and can be monitored as an indication of tumor activity. An increased amount of these metabolites in the urine frequently heralds recurrence of the tumor at a time when it is not apparent on physical examination or by radiologic studies.

2) The development of a bizarre movement disorder (opso-myoclonus) which may actually be the presenting feature of the disease. The course of this manifestation is extremely variable—it may persist even when all other manifestations of the tumor are absent or it may resolve spontaneously or in conjunction with ACTH therapy.

3) On some occasions a neuroblastoma may mature into a more benign histologic cell type-ganglioneuroblastoma or ganglioneuroma).

4) The role of the body's immune defense system in controlling spread of this tumor may be very important.

Rhabdomyosarcoma

This highly malignant tumor arising from embryonic mesenchyme has an incidence close to, if not exceeding, that of neuroblastoma. It is not generally recognized as being so common, possibly because the initial pathologic diagnosis is incorrect in approximately 50% of cases, due to the ambiguity of its histologic features.[14] However, it has a characteristic electron-micrographic (E/M) appearance which is diagnostic. For this reason, a portion of tumor should be fixed in 2.5% glutaraldehyde at the time of biopsy so that E/M sections can be prepared in case a definite diagnosis cannot be made from routine histologic sections.

Sites of involvement vary from head and neck (orbit, nasopharynx, paranasal sinuses, palate, middle ear) to lower genitourinary tract and extremities. Common sites of metastasis are lung and bone.

Despite the highly malignant nature of the tumor and its previously poor prognosis, recent therapeutic regimens involving judicious surgery (usually wide local excision), high dose combination chemotherapy, and radiation therapy, have resulted in markedly improved survival data even in patients with widespread disease at the time of diagnosis. Using such a regimen, Wilbur and colleagues[15] found that 76% of 21 children with inoperable or metastatic disease at onset were alive without evidence of disease for a period of 1-4 years. Because of the excellent results currently obtainable, especially in Stage I disease, radical surgery such as amputation

TABLE II

Survival by Stage for Childhood Hodgkin's Disease[9]

Stage*		Percent Survival for 5 years
I	Confined to single lymph node region	>80%
II	More than one lymph node region involved but confined to one side of diaphragm	70%
III	Lymph node regions on both sides of diaphragm involved	50%
IV	Disseminated disease with organ involvement	35%

*May be substaged as A or B depending on the absence (A) or presence (B) of systemic symptoms (fever, weight loss, night sweats).

Table III

Two-Year Survival in Neuroblastoma by Stage[11]

Age	Stage I (Confined to site of origin)	Stage II (No longer confined to site of origin, but not crossing midline)	Stage III (Extending in continuity beyond midline)	Stage IV (Disseminated disease)	Stage IV_S (See text)	Total
<1 year	90%	88%	50%	24%	90%	71%
1-2 years	80%	63%	50%	0%	100%*	29%
>2 years	67%	27%	17%	3%	50%	10%
Total Survival	84%	63%	33%	5%	84%	32%

*1 case only

of an involved limb is no longer indicated. Instead, wide excision of primary tumor with subsequent chemotherapy and radiotherapy should be employed.

Wilms' Tumor

This is probably the third commonest solid tumor of childhood (excluding brain tumors). The current mode of treatment combines removal of the involved kidney with radiotherapy to the tumor bed and chemotherapy with Vincristine, Actinomycin D, and sometimes Adriamycin. Since approximately 5-10% of Wilms' Tumors occur bilaterally, both kidneys should be examined at the time of initial surgery. Using such treatment it has been possible to obtain 70-80% long-term survival.[15]

The commonest site of metastasis is the lungs. However, unlike the case with most other tumors, even when pulmonary metastases are present it is possible to salvage many Wilms' Tumor patients. Solitary pulmonary metastases should be removed by wedge resection; multiple metastases can be treated with radiotherapy and/or chemotherapy. It is most important not to give up on these patients as they are still potentially curable.

REFERENCES

1. Vital Statistics of the United States, 1969.
2. Koop, C.E.; Kaufmann, H.J.: The diagnosis of cancer in children. *Semin. Oncology* 1:5, 1974.
3. McIntosh, S.; Pearson, H.: Treatment of childhood leukemia. *J. Pediat.* 85:899,1973.
4. Holland, J.F.; Glidewell, O.: Chemotherapy of acute lymphocytic leukemia of childhood. *Cancer* 30:1480, 1972.
5. Aur, R.J.A.; Simone, J.V.; Hustu, H.O., et al.: Central nervous system therapy and combination chemotherapy of childhood lymphocytic leukemia. *Blood* 37:272, 1971.
6. Simone, J.V.; Holland, E.; Johnson, W.: Fatalities during remission of childhood leukemia. *Blood* 39:759, 1972.
7. Ingelfinger, F.J.: Information about cancer treatment. *N. Engl. J. Med.* 287:101, 1972.
8. Rosenberg, S.A.; Kaplan, H.S.: Hodgkin's disease and other lymphomas. *Calif. Med.* 113:23, 1970.
9. Young, R.C., DeVita, V.T.; Johnson, R.E.: Hodgkin's disease in childhood. *Blood* 42:163, 1973.
10. DeVita, V.T., Serpick, A.A., Carbone, P.P.: Combination chemotherapy in the treatment of advanced Hodgkin's disease. *Ann. Intern. Med.* 73:881, 1970.
11. Evans, A.E., as quoted by Sinks, L., in Holland, J.F.; Frei, E. III (ed.): *Cancer Medicine,* Philadelphia, Lea and Febiger, 1973.
12. Koop, C.E.; Johnson, D.G.: Neuroblastoma: an assessment of therapy in reference to staging. *J. Pediat. Surg.* 6:595, 1971.
13. Evans, A.E.; D'Angio, G.J.; Randolph, J.: A proposed staging for children with neuroblastoma. *Cancer* 27:374, 1971.
14. Pinkel, D.; Pratt, C., in Holland, J.F.; Frei, E. III (ed.). *Cancer Medicine,* Philadelphia, Lea and Febiger, 1973.
15. Wilbur, J.R.; Sutow, W.W.; Sullivan, M.P., et al.: Successful treatment of rhabdomyosarcoma with combination chemotherapy and radiotherapy. *Am. Soc. Clin. Oncol.* 7: Abstract 56, 1971.
16. Wolff, J.A.; D'Angio, G.; Hartmann, J., et al.: Long-term evaluation of single versus multiple courses of Actinomycin D therapy of Wilms' tumor, *N. Engl. J. Med.* 290:84, 1974. ◄

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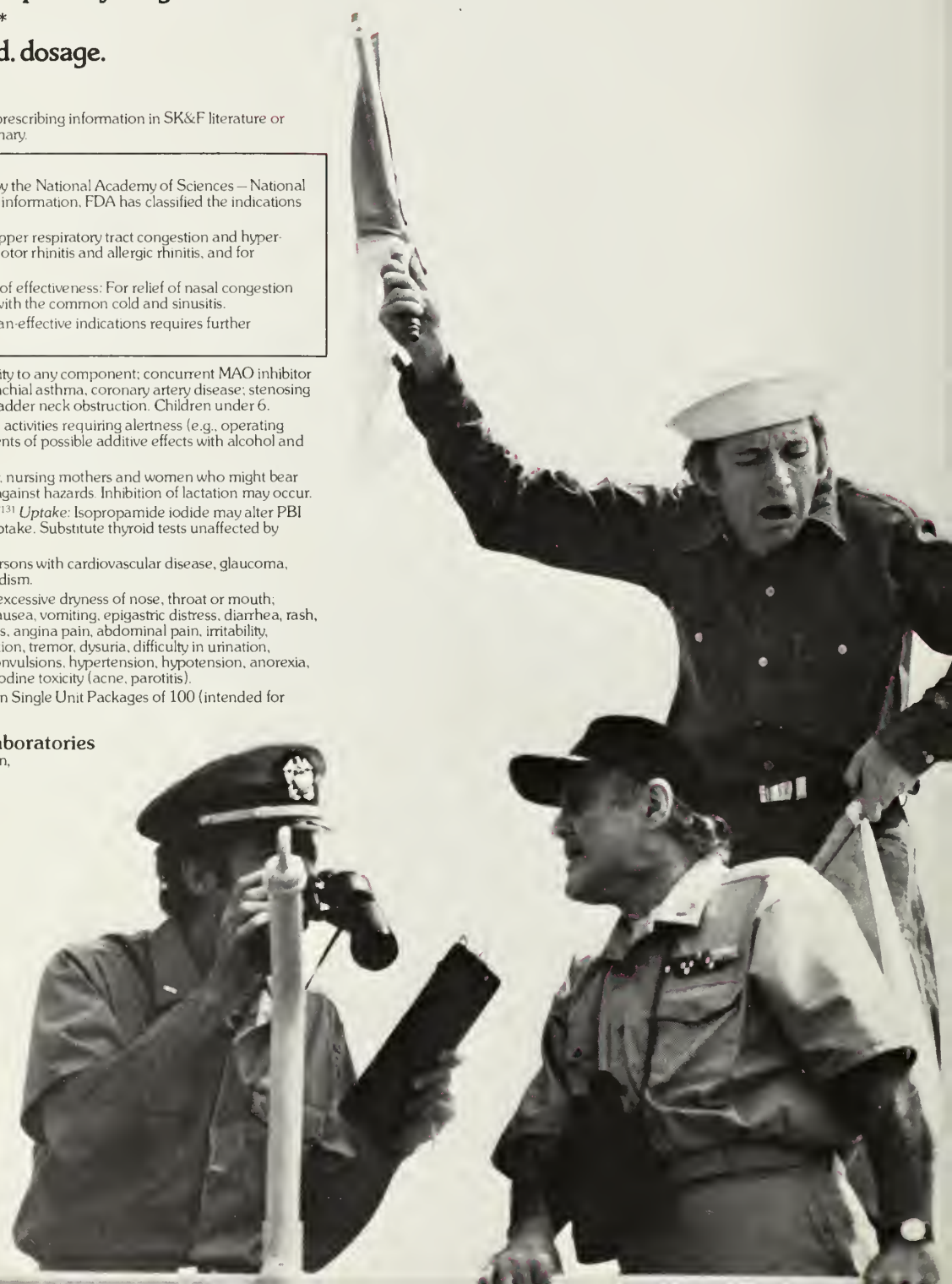
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A Reanalysis of Some Data from "A Study of Motivational, Attitudinal and Environmental Deterrents to the Taking of Physical Examinations that Include Cancer Tests"

EUGENE E. LEVITT, Ph.D.[1]
DAVID RUBINSTEIN, M.S.
Indianapolis

"CONSIDERABLE progress has been made over the years in saving the lives of cancer victims. Though no reliable figures are available, it is generally believed that prior to World War II, less than 20% of cancer patients recovered. By 1948, this figure had risen to 25% and, by 1956, to 33%. But there has been no progress in the past 12 years.

"One potential reason for this undesirable plateau appears to be paramount. Regardless of the progress of medical science, no doctor or hospital or technique can save the life of a cancer victim whose illness remains unidentified until it is too late for treatment. In 1964, the American Cancer Society's Committee on Information called for a study of 'why some people delay in going to a physician and others do not; why so little progress is being made in bringing patients to physicians when their cancers are still localized; why check-ups are not more widely accepted.' The following year, ACS commissioned Lieberman Research of New York to carry out this study. The report, which appeared in October of 1966, is entitled, 'A Study of Motivational, Attitudinal and Environmental Deterrents to the Taking of Physical Examinations that Include Cancer Tests.' The data in that report are based on personal interviews with 2,100 individuals aged 21 years and older located in 32 cities of various sizes in different parts of the country. The interviews were conducted between March 14 and April 5. 1966."[2]

The Lieberman survey yielded an enormous complex of data. The personal interview questionnaire has 18 pages. Lieberman's report itself is 311 pages long and contains 198 tables of substantive data.

The findings were analyzed in traditional market research fashion —that is, almost entirely by univariate statistical analyses. This type of analysis is minimally revealing, especially in a multivariate investigation. In such a study, many of the factors turn out to be interrelated. The interpretation of a relationship with a criterion is then much different than when the factors are independent. For example, the Lieberman investigation found that 29% of individuals who had never had a cancer checkup believe that a person must have a noticeable symptom in order to go for a physical examination. Also, 38% of this group insisted that they could not afford cancer checkups. Now, are these two percentages totally independent, and if not, to what extent do they overlap? Do all of the subjects who believe that only a symptom warrants a physical examination, plead lack of money? If so, the former finding is useless as a predictor of behavior in light of the latter percentage. But if the two percentages are entirely independent, we must conclude that there are two important and unrelated reasons for avoiding cancer checkups.

Univariate statistical analyses also have very limited explanatory capacity. They may, in fact, lead to erroneous or misleading inferences. Consider this simple illustration. Income and educational level are invariably related in any large group of people. The data indicate that people of higher educational attainment are more likely to go for cancer checkups. But is this because they are better educated or more intelligent, or because they can afford medical attention? Women are more likely to have had cancer examinations than men. Is this a consequence of better education, higher income, or more anxiety about becoming a cancer victim? Univariate analyses usually cannot provide an answer.

From the Indiana University School of Medicine, 1100 W. Michigan St., Indianapolis 46202.

[1]Chairman, Cancer Prevention Study Committee, American Cancer Society, Indiana Division.

[2]Levitt, E. E.: Obstacles to the prevention and treatment of cancer: a critical summary of a crucial investigation. *Occupational Health Nursing* 1970, pp. 19-22.

In the multivariate study, multivariate statistical analysis is the superior strategy. This paper reports a belated multivariate statistical treatment of a portion of the data from the Lieberman study.

We selected or created five dependent variables from the Lieberman questionnaire. All concerned going for physical examinations and/or cancer tests. Four of them are straightforwardly taken from the questionnaire: Questions 11, 16, 21, and 26a. A fifth variable was created by melding Questions 1-4 inclusive from the Lieberman questionnaire. This is relabeled as Dependent Variable I.

We then chose 23 independent variables. Nine of these were descriptions of the patient in terms of personal characteristics and demographic data. The other 14 were those questions in which we were most interested for theoretical reasons. They formed six small clusters:

Effectiveness of diagnosis and treatment (questions 34 and 53)
Probability of contracting cancer (questions 48a and 49)
Current state of health (questions 64 and 69)
Physician's influence (questions 62a and 63a)
Inconvenience involved in cancer testing (questions 40 and 44)
Personal knowledge of cancer victims (questions 55a, 55b, 56a and 56b)

Dummy variables were created for the naturally categorical variables of marital status, religion and region of residence, so that there were actually 29 independent variables employed in the multivariate analyses.

We deliberately avoided including variables that might obscure critical findings. For example, the original Lieberman data show that one of the best predictors of intent to have future physical examinations is a current history of such examinations. All that this relationship means is that the respondent has already established a stable behavior pattern. It does not reveal how that pattern became established, which is the information that we are seeking.

Each dependent variable was analyzed with all the independent variables, but separately from all other dependent variables. Thus, there were five multiple regression analyses attempting to predict responses on the dependent variables from the independent variables. The computer program was adjusted so that every independent variable was included in the analysis, regardless of how trivially it contributed to the multiple regression coefficient. An arbitrary decision was then made to include in the prediction battery only those independent variables which contributed at least .5% to the variance of the multiple regression coefficient—that is, increased the coefficient itself by at least .01 units.

Our independent variables were variably effective in predicting the dependent variables. The multiple regression coefficient for Dependent Variable I was only .328 for all of the independent variables. The bulk of the variance was accounted for by seven variables, as indicated in Table 1.

The overall situation was similar for Dependent Variable II, which had a multiple regression coefficient of .334. Almost all was accounted for by only two variables, as indicated in Table 2.

We did considerably better with Dependent Variable III, which had a multiple regression coefficient of .450. However, again the vast majority of the variance was accounted for by only three of the independent variables, as shown in Table 3.

We predicted Dependent Variable IV the poorest, as reflected in a multiple regression coefficient of only .275. Three variables accounted for the bulk of the prediction, as shown in Table 4.

We were most effective in predicting Dependent Variable V. The multiple regression coefficient was .518 and five variables accounted for most of the variance, as shown in Table 5.

TABLE 1

Predicting Responses to Dependent Variable I:
"Have you ever gone to the doctor for a complete physical checkup even though you were feeling all right? (If so, how often?)"

Those who respond "Yes" to the dependent variable question are described below

My doctor feels that I should have a physical checkup that includes cancer tests.
I can afford a physical checkup that includes cancer tests.
I do not live in the Midwest.
I tend to be an older person.
If my doctor told me to, I would get a physical checkup that included cancer tests more often.
I tend to be better educated.

TABLE 2

Predicting Responses to Dependent Variable II:
"Have you yourself ever gone to a doctor or a clinic specifically for a cancer checkup even though there was nothing particularly bothering you?"

Those who respond "Yes" to the dependent variable question are described below

I am more likely to be a woman.
My doctor feels that I should have a physical checkup that includes cancer tests.

Tables 1-5 indicate that the two best predictors of whether an individual will take prophylactic action against cancer are the individual's sex and the reported influence of the family physician. Preventive action is considerably more likely if the person is a woman rather than a man, and if the family physician feels that it is necessary.

Socioeconomic factors appear in two of the five tables, but not in the precise form suggested by the original Lieberman data. The better educated have some tendency to be more inclined to take preventive action, but annual income per se is not the relevant financial variable. Rather, it is the respondent's own estimate of whether or not he can financially afford the visit to the doctor or clinic. Our data show clearly that the can-afford-it variable is something quite different from sheer income. The correlation between the two is only .34, indicating that almost 90% of the belief that one can afford a physical checkup is a function of factors other than income.

The fifth variable that appeared in more than one of the tables is a positive response to the question, "Suppose your doctor told you you're not getting a physical checkup that includes cancer tests often enough and you should be getting such check-ups more often. Would you do it?" The significance of this factor is supported by the original Lieberman data which show that 90% responded affirmatively to the question, almost equally divided between those who have had cancer tests and those who never have.

In summary, we can say that the prophylactic-minded individual is likely to be a woman of above average educational attainment who believes that she can afford cancer checkups and is influenced by her family physician.

Five other variables were involved in only one or another of the regression analyses. Older people and those who live in parts of the country other than the Midwest tend more often to go for regular checkups. Those who have been tested for cancer, not as part of a complete physical or a specific cancer testing, tend more often to be married (women) and to have had a history of familial cancer. Finally, those who say that they are likely to have cancer tests in the near future are inclined to believe that such testing can disclose cancer in an early stage.

The following variables failed to predict any of the prophylactic behaviors significantly: current state of health; the fact of smoking cigarettes; respondent's estimate of his probability of getting cancer compared to other people; difficulty in getting time off for cancer tests; estimate of the proportion of victims who recover from cancer; race, and religion.

These, then, are the relevant findings from the Lieberman investigation. It is not too late to find applications for them; it is doubtful that they have become out of date in eight years. It is likely, however, that they will become outdated eventually. Meaningful applications of the data in this invaluable study should be developed in the near future. ◄

TABLE 3

Predicting Responses to Dependent Variable III:
"As far as you know, have you ever had any cancer tests when you've gone for a complete physical checkup?"

Those who respond "Yes" to the dependent variable question are described below

My doctor feels that I should have a physical checkup that includes cancer tests.

I am more likely to be a woman.

I can afford a physical checkup that includes cancer tests.

TABLE 4

Predicting Responses to Dependent Variable IV:
"As far as you know, have you ever had any cancer tests when you've gone to the doctor for some other reason besides a complete physical checkup?"

Those who respond "Yes" to the dependent variable question are described below

I am more likely to be a woman.

I am more often married.

There is a tendency for more people in my family to have had cancer.

TABLE 5

Predicting Responses to Dependent Variable V:
"In the next two or three years, how likely is it that you will go for some kind of physical checkup that includes cancer tests?"

Those who say that it is likely are described below

My doctor feels that I should have a physical checkup that includes cancer tests.

I am more likely to be a woman.

I tend to be better educated.

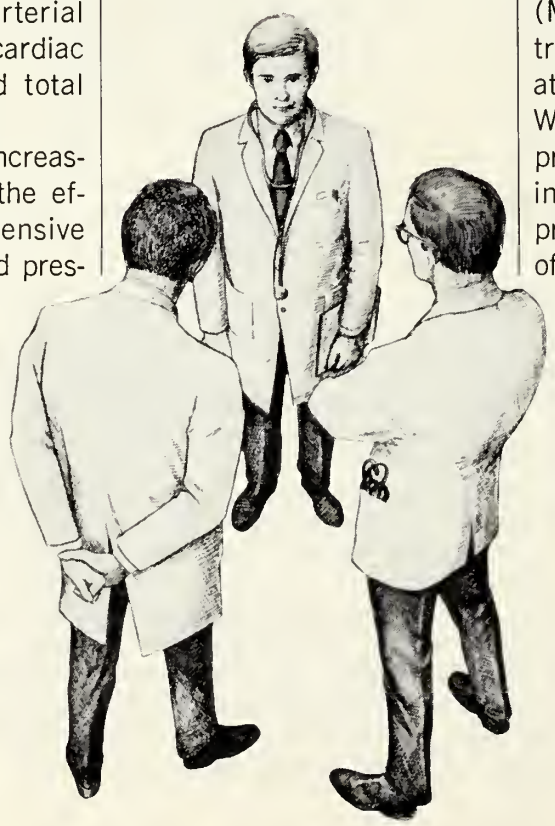
I think that it is likely that a physical checkup that includes cancer tests will detect a cancer that is in an early stage.

If my doctor told me to, I would get a physical checkup that included cancer tests more often.

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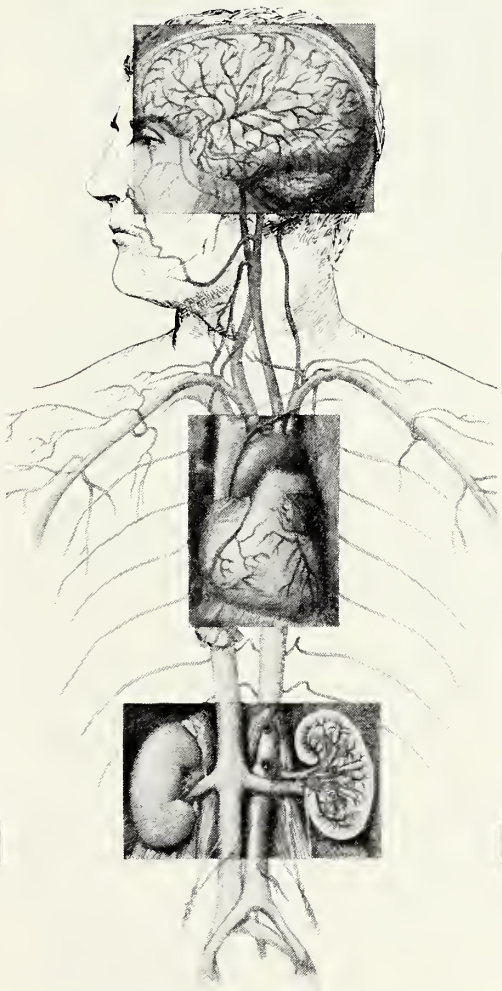
And so, physicians are increasingly concerned with the effects of an antihypertensive agent not only on blood pressure itself but also on the hemodynamic pattern—in short, with the total effect of the drug. *Does* it indeed help lower blood pressure effectively? *Is* peripheral resistance reduced? *Are* cardiac output and renal functions maintained? And, also, is there likely to be drug-induced postural hypotension serious enough to pose a threat to the patient's cerebrovascular status?



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the more physicians rely on this unique antihypertensive



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It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyldopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. For more details see the brief summary of prescribing information.

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In most cases of sustained moderate hypertension

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smoothly lowers blood pressure

Contraindications: Active hepatic disease, such as acute hepatitis and active cirrhosis. Known sensitivity. Not recommended in pheochromocytoma. Unsuitable in mild or labile hypertension responsive to mild sedation or thiazide therapy. Use cautiously in patients with history of previous liver disease or dysfunction.

Warnings: It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyldopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. Read this section carefully to understand these reactions.

With prolonged methyldopa therapy, 10% to 20% of patients develop a positive direct Coombs test, usually between six and twelve months of therapy. Lowest incidence is at daily dosage of 1 g or less. This on rare occasions may be associated with hemolytic anemia, which could lead to potentially fatal complications. One cannot predict which patients with a positive direct Coombs test may develop hemolytic anemia. Prior existence or development of a positive direct Coombs test is not in itself a contraindication to use of methyldopa. If a positive Coombs test develops during methyldopa therapy, determine whether hemolytic anemia exists and whether the positive Coombs test may be a problem. For example, in addition to a positive direct Coombs test there is less often a positive indirect Coombs test which may interfere with cross matching of blood.

At the start of methyldopa therapy, it is desirable to do a blood count (hematocrit, hemoglobin, or red cell count) for a baseline or to establish whether there is anemia. Periodic blood counts should be done during therapy to detect hemolytic anemia. It may be useful to do a direct Coombs test before therapy and at six and twelve months after the start of therapy. If Coombs-positive hemolytic anemia occurs, the cause may be methyldopa and the drug should be discontinued. Usually the anemia remits promptly. If not, corticosteroids may be given and other causes of anemia should be considered. If the hemolytic anemia is related to methyldopa, the drug should not be reinstituted. When methyldopa causes Coombs positivity alone or with hemolytic anemia, the red cell is usually coated with gamma globulin of the IgG (gamma G) class only. The positive Coombs test may not revert to normal until weeks to months after methyldopa is stopped.

Should the need for transfusion arise in a patient receiving methyldopa, both a direct and an indirect Coombs test should be performed on his blood. In the absence of hemolytic anemia, usually only the direct Coombs test will be positive. A positive direct Coombs test alone will not interfere with typing or cross matching. If the indirect Coombs test is also positive, problems may arise in the major cross match and the assistance of a hematologist or transfusion expert will be needed.

Fever has occurred within first three weeks of therapy, sometimes with eosinophilia or abnormalities in liver function tests, such as serum alkaline phosphatase, serum transaminases (SGOT, SGPT), bilirubin, cephalin cholesterol flocculation, prothrombin time, and bromsulphalein retention. Jaundice, with or without fever, may occur, with onset usually in the first two to three months of therapy. Rarely fatal hepatic necrosis has been reported. These hepatic changes may represent hypersensitivity reactions; periodic determination of hepatic function should be done particularly during the first six to twelve weeks of therapy or whenever an unexplained fever occurs. If fever, abnormalities in liver function tests, or jaundice appear, stop therapy with methyldopa. If caused by methyldopa, the temperature and abnormalities in liver function characteristically have reverted to normal when the drug was discontinued. Methyldopa should not be reinstituted in such patients.

Rarely, reversible reduction in leukocyte count with primary effect on granulocytes has been seen. Reversible thrombocytopenia has occurred rarely. When used with other antihypertensive drugs, potentiation of antihypertensive effect may occur.

Use in Pregnancy and Childbearing Age—Not recommended in pregnancy. In women of childbearing age, weigh potential benefits against possible fetal hazards.

Precautions: Methyldopa may interfere with measurement of: uric acid by the phosphotungstate method, creatinine by the alkaline picrate method, and SGOT by colorimetric methods. Since methyldopa causes fluorescence in urine samples at the same wavelengths as catecholamines, spuriously high levels of urinary catecholamines may be reported. This will interfere with the diagnosis of pheochromocytoma. Stop drug if involuntary choreoathetotic movements occur in patients with severe bilateral cerebrovascular disease. Patients may require reduced doses of anesthetics; hypotension occurring during anesthesia usually can be controlled with vasopressors. Hypertension has occurred after dialysis in patients on methyldopa because the drug is removed by this procedure.

Adverse Reactions: Sedation, usually transient, may be seen during initial therapy or when dosage is increased. Headache, asthenia, or weakness may be noted as early, transient symptoms. Symptoms associated with effective lowering of blood pressure are occasionally seen and include dizziness, lightheadedness, and symptoms of cerebrovascular insufficiency. Angina pectoris may be aggravated. Symptoms of orthostatic hypotension may occur; if symptoms occur, reduction of dosage is suggested. Bradycardia, nasal stuffiness, mild dryness of mouth, and gastrointestinal symptoms including distention, constipation, flatus, and diarrhea occur occasionally; these generally can be relieved by reducing dosage. Nausea and vomiting have been reported in only a few patients. Sore tongue or "black tongue," pancreatitis, and inflammation of salivary glands may occur.

Weight gain and edema occur infrequently and are relieved by administering a thiazide diuretic; if edema progresses or signs of pulmonary congestion appear, discontinue drug. A rise in BUN has been observed. Other rare reactions include breast enlargement, lactation, impotence, decreased libido, skin rash, mild arthralgia, myalgia, paresthesias, Bell's palsy, parkinsonism, psychic disturbances including nightmares, reversible mild psychoses or depression. Urine exposed to air after voiding may darken because of breakdown of methyldopa or its metabolites.

Note: Dosage should be limited initially to 500 mg daily when following previous antihypertensive agents other than thiazides. Maximal recommended daily dose is 3.0 g. Patients with impaired renal function may respond to smaller doses than patients with normal kidney function. Syncope in older patients has been related to increased sensitivity in those with advanced arteriosclerotic vascular disease; this may be avoided by lower doses. Tolerance occasionally seen either early or late, but more likely between second and third month after initiation of therapy; increased dosage or combined therapy with a thiazide frequently restores effective control.

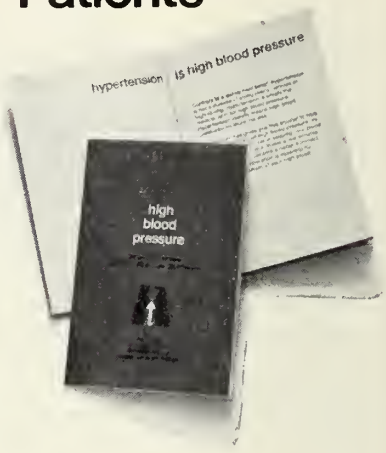
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addendum

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KEY ROLE OF THE PHYSICIAN IN BREAST SELF-EXAMINATION

Breast cancer is a major concern of American women, according to a recent Gallup Study for the American Cancer Society. Although aware that early discovery improves the chances of cure, and that breast self-examination can lead to early detection, fewer than one in five women practice breast self-examination and only half have an annual breast examination by a physician.

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Physicians now play the *single most important role* in getting women to practice breast self-examination. Nonetheless, their role is still quite limited in terms of what it could be.

Twenty-three percent of all women have become aware of breast self-examination through a personal discussion with a physician, and another 9% by a pamphlet in a physician's office. Thus, a total of 32% of all women have become aware of breast self-examination through a physician. This compares with 17% who first become aware through a magazine article, 8% television, 8% newspapers and 2% radio. In addition to the 9% who obtained a pamphlet in a physician's office, another 6% first became aware of breast self-examination through a pamphlet obtained elsewhere. Thus, a total of 15% of women first became aware through reading a pamphlet.

Since physicians are particularly effective in translating mere awareness of breast self-examination into actual practice, it is unfortunate that more do not make a greater effort to familiarize women with it. Only 35% of all women report that a physician has ever brought up the topic with them. Furthermore, only 24% of all women have received personal instruction from a physician on how to do breast self-examination. Even among women who see a gynecologist for periodic check-ups, only 34% have been instructed by a physician on how to do breast self-examination.

Whether one has been personally instructed on how to do breast self-examination sharply differentiates practicers from non-practicers. *The overwhelming majority* (92%) *of women who have received personal instructions have practiced breast self-examination,* 33% on a monthly schedule and 45% less regularly, during the preceding year. In contrast, among aware women who have not received any instructions at all, only 43% have ever practiced it, and a mere 14% have done so monthly in the past year.

The fact that breast examinations are not performed routinely by physicians contributes to the problems noted earlier, that only a minority of women have their breasts examined by a physician at least once a year. The vast majority (82%) of all adult women report they have seen a physician for some reason or other at least once during the past year. *Thus, if physicians were to make it a standard practice to perform breast examinations at every visit,* this could dramatically increase the proportion of women who have breast examinations at least once a year without any change in the frequency with which women now see a doctor.

Moreover, there is considerable receptivity to having physicians explain what they are doing and why, as a means of reducing embarrassment during breast examinations. Seventy-two percent of all women said this would reduce embarrassment, 24% that it would make no difference, and only 2% that it would be more embarrassing. For most women, explaining the examination procedure lessens whatever embarrassment does exist, and in a way that provides an excellent basis for teaching breast self-examination. If breast examinations were to be performed routinely, with accompanying explanations, this could prove to be a very effective way of increasing the proportion of women who regularly practice breast self-examination.

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January 15, 1975

"Current Concepts in Cancer Chemotherapy and Immunotherapy" (For information refer to the October ISMA Journal.)

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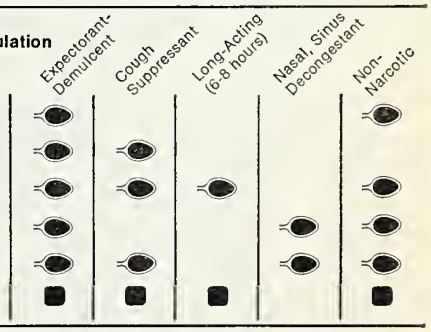
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A Recipe for Chaos?

Professional Standards Review Organizations (PSROs) were analyzed and discussed by Dr. Kerr L. White in an article which appeared in *The Western Journal of Medicine* last April.

Dr. White, who is Professor of Medical Care and Hospitals, The Johns Hopkins University, thinks that, while broader accountability is inevitable, the PSRO prescription as currently being discussed may well be a recipe for chaos. He considers that the below listed five assumptions underlying PSRO should not go unexamined.

1. Practitioners in the United States are distributed bimodally with respect to their clinical competence—that is, there are "good doctors" and "bad doctors" and we know how to tell them apart. It seems to be assumed further that the "good doctors" will be the ones to say which are which.

2. Medical practice is more usefully assessed in relationship to "diagnoses" and "processes" than in relationship to "performance" or "outcomes" of patient care.

3. Contemporary medicine has a substantial number of clearly defined and well-understood preventive, diagnostic and therapeutic forms of intervention for which the clinical efficacy and patient care utility have been objectively assessed by means of randomized clinical trials or other credible evidence, and we know precisely what to do for the majority of the most common health problems brought to the medical profession.

4. Health information systems now exist that will permit objective statements to be made about the adequacy of care given to a specific patient by a specific practitioner at a specific time and place.

5. Sub-optimal patient care, however defined and measured, is due more to the inadequacies of the individual practitioner than to failures in the organization of health care systems or institutions or to the inappropriate allocation of priorities and resources by society.

In his discussion of these five assumptions, Dr. White concludes that they are either untrue, only partially true or are, at the present time, incapable of realization and accomplishment.

His conclusions read as follows:

In summary, I question the present emphasis on "process" standards directed at physicians' practices that seems to characterize much of the thinking about PSROs because:

1. Much work needs to be done to separate efficacious procedures from the rest. For only a small proportion of the problems presented by pateints at the level of primary care do we know enough to set "process" standards, or even to define what currently goes on.

2. Much more needs to be done to build up population-based, problem-oriented information systems that use data parsimoniously for making useful decisions about the medical care provided by hospitals and other health care institutions for the populations they serve.

3. The use of predetermined "process" standards based on data of uncertain validity collected from unrepresentative samples would, in my judgment, be anti-intellectual, unduly rigid, and discourage clinical initiative, and would be potentially hazardous to patients and inflationary.

4. "Systems" failure may be as important or more important than "practitioner" failure if medical care is unacceptable with respect to access, quality and cost. We should focus on hospitals and systems before we focus on individual physicians and their individual patients.

5. An educational rather than a punitive approach is preferable if medicine is to maintain its professional traditions. Do we want to catch a few rascals, or do we want to improve medical care for all citizens?

Reference: White, K. L.: Caveats for PSRO's. *West. J. Med.* 120:338-343, Apr. 1974.

Guest Editorials

Peer Review and All That

Three Little Words

There are only a few nouns in the English language that have two directly opposite meanings. Such a one is "peer." As if that were not remarkable enough, the word also has a third meaning as a verb that has no etymological relationship to the other two meanings.

The first definition is *"Peer:* one of superior rank or position, a nobleman, a holder of one of the five degrees of British nobility: Duke, Marquis, Earl, Viscount, or Baron." Its second meaning is more humble: *"Peer:* one of the same rank, an equal, a comrade."

Will the peer review process of the Professional Standards Review Organizations (PSRO) bring together a group of comrades, reviewing records and clinical procedures

out of mutual interest and concern for the welfare of the patient, as equals? If so, this new legislation will survive and might even go down in history as a triumph for self-regulation in a voluntary medical care delivery system.

Or will each PSRO nominate a new nobility, a dapper dukedom in the elegant echelons of medical politics, a veritable "House of Peers" to review the work carried out downstairs, in the Commons, by the ordinary doctors there?

If the second pathway is taken, the medical profession will fail to cooperate. If peer review involves a new nobility, the system will fail despite the arm-twisting of a politicized bureaucracy, induced financial penalties, and the "leverage of constraints." This delightful term "leverage of constraints" (politely coined by the Department of Health, Education, and Welfare) means, in simple English, that you will not be paid for your work unless you conform to the new PSRO regulations.

Medical care cannot be given under coercion. It is a form of social intercourse involving a "collective action" between doctor and patient. It cannot be carried out at the end of a gun, any more than other forms of intercourse.

Being, like most surgeons, a persistent optimist, I want to believe that the peer review process will improve the quality of patient care. Unfortunately, current trends are in the other direction. The entire thrust has been distorted to "cost containment." The PSRO will accomplish merely the definition of allowable or permissible charges. There is no clear connection between this frantic political activity and the quality of clinical care.

Let us consider an example. A 45-year-old woman wishes to have a hysterectomy because of recurrent vaginal bleeding from a small submucous fibroid. The "normalized" hospital stay for a hysterectomy is 8.4 days. Certain laboratory tests and examinations are required and acceptable. If these conditions are met, the surgeon and the physician are paid and so is the hospital. But we still have no idea of whether or not the hysterectomy was really needed. Would she be better off just to await the natural menopause? We have no idea whether or not the inevitable urethral catheterization emptied the bladder of urine but filled it with *Escherichia coli,* leading to persistent pyelonephritis. We are not told whether or not the laboratory "norms" contained an adequate screen to determine that her anemia was actually pernicious anemia, rather than blood loss. And certainly we have no idea as to whether or not the patient and her husband understood clearly what was being advised and what was involved. We have no concept of whether or not the anesthetist was competent to introduce the endotracheal tube without injuring the vocal cords, whether or not an adequate allergic history of prior anesthetics was taken before administering a drug such as halothane to the point of deep coma. We have no concept as to whether or not the scrub nurses that day were a little careless and brought instruments into the operating room from the one next door where an abscess was being drained. In short, all the elaborate PSRO conditions were met, but we have gained no insight into the quality of the patient's care.

Moreover, when the patient did get ready to go home after 8.4 days, the surgeon still felt that she was a little weak and wobbly and should not really go home quite yet. He was a little worried about her strength. Her pulse was still elevated, even though the electrocardiogram appeared to be normal. Looking over his rule book for PSRO, he could find no identifiable complication that would justify her further stay in the hospital. If he asked her to stay on for a day or two, neither he nor the hospital would be paid. The patient would have to pay out of her own pocket. There would always be the slight suspicion that maybe the doctor had done something evil. And possibly he would be asked to pay the additional hospital bill out of his own pocket.

So, the PSRO conditions being met, she went home. And climbing the stairs two days later, she suffered a fatal heart attack. Looking back over that last day in the hospital, the consultant for the plaintiff's lawyers points out that maybe there was a little evidence of electrical instability in that ECG and that her medications and electrolyte values should be rechecked because of the danger of an arrhythmia.

Such a case tells us of the glaring faults and shortcomings of the PSRO as now being advocated by federal and local government. In addition, it may signal one of the most famous lawsuits in the history of American medicine. The chairman of the local PSRO could, of course, be sued for malpractice. It was his insistence on meeting these arbitrary rules that forced the patient to be sent home before the doctor felt it was wise. This caused her death.

Such painful examples can be strung out far longer than this editorial should stretch. They merely emphasize that the definition of the length of stay, permissible charges, and norms for patient care (instituted by a self-appointed peerage) may constitute peer review; they do not constitute either the practice of medicine or the definition of high-quality care.

The passage of the Bennet Amendment will mark the beginning of a period of extravagant expenditure of public funds for the establishment of a new bureaucracy to regulate medical practice. This new set of rules will signalize the beginning of an intense power struggle, long latent or dormant, between physicians and those who seek to enter the doctor-patient interface. This truly will be a struggle between "town and frown." The value of peer review as it grows, blossoms, and then later withers, will depend on which of these two meanings of the word "peer" finally comes to prevail.

The definition of payable charges

for in-hospital medicine is surely but a petty objective in the overall battle plan for the improvement of American medical care. We should instead be devoting our attention to primary care, home care, family care, and the work of the first-contact physician. The peer review process and PSRO do absolutely nothing about these critical matters. They leave untouched the problems of access, nonuniform distribution, availability of personnel, training, productivity, competence definition, specialty certification, staff credentialling, and the educational process.

It took the Regional Medical Programs (RMP) a decade to die. They were launched with about the same amount of fanfare. It is my prediction that the PSRO will die more quietly, without too much of a convulsive struggle, in about seven years. Give it until 1980.

The RMP supplied kudos, national appointments, employment opportunities, and local prominence for administrative personnel who enjoy playing the game of medical politics. It was grossly ineffective by any clinical criteria. It did not help a number of patients appropriate to the expenses incurred. It demonstrated again that our federal government is not an effective operational modality at the doctor-patient interface.

There is a general social principle known as the "generational acceleration of social change." We would estimate that this will act to accelerate the death of PSRO even faster than RMP.

Peering dimly into the future, then, we can discern what sorts of peers will do the peer review. We predict that they will constitute a new nobility (authority without peer), peering into the records of patients written by physicians whom they no longer regard as their peers. An essentially malignant process, this cancer will be lethal and PSRO will die because the wrong definition of the key noun came to prevail.—**Francis D. Moore, M.D., Peter Bent Brigham Hospital, Boston, Mass. Reprinted with permission of** *Archives of Survery* **108: 397-398, 1974, and the author.**

Let's Avoid Another Round of Controls

RECENT polls show that a sizeable plurality of Americans understand correctly that government causes inflation, not business or labor. And yet, government has just established a "Council on Wage and Price Stability," the purpose of which is to tell business and labor not to cause inflation.

It is a development I view with serious misgivings.

If the new Council has no power to enforce its views about the desirability of any particular wage or price change—and for the moment that is the case—then it is merely a tranquilizer, designed to create an illusion of action against inflation. But even a tranquilizer can have some serious side-effects.

If Congress and the President bring the federal budget into balance and the Federal Reserve System holds the growth of the money supply down to a noninflationary rate, inflation will subside and there will be no need for the Council.

Even the *threat* of new controls can have the effect of worsening inflation, because business and labor try to get the biggest increases they can before controls are imposed, figuring they may not be able to get what they need afterward.

Both the President and Congressional leaders recognize the potential for triggering such a process. That's why they have strongly denied any intention of giving the Council enforcement powers *at this time.*

But I don't think these denials are enough. The Council itself will constitute a threat-in-being as long as it exists. The pressures to give it enforcement power will be enormous. And the enforcement power could be created swiftly, once the decision was made.

I hope the leaders of business and labor will do everything they can to avoid giving the Council an excuse to ask for more power. But even in this course there is danger: To the extent that wage or price changes indicated by market conditions are foregone for political reasons, the "powerless" Council will tend to create the same kind of shortages, distortions and misallocations of resources that would result from genuine controls.

The real solution is for all of us to keep the pressure on Congress to restrain the federal budget. Let's lay off the tranquilizers.—**Arch Booth, president, Chamber of Commerce of the United States.**

Editorial Notes . . .

"Health Insurance News" transmits a report from the U.S. Center for Disease Control to the effect that the nation is in the midst of a lice epidemic—800% increase since 1963. Lice is the plural of louse. Nevertheless, one health commissioner issues a warning: "Lice are a problem which cuts across ethnic and social lines." However you say it, body lice may be an alternate diagnosis to scabies.

Cobra venom factor will reduce the size of the necrotic area caused by ligature of a coronary artery in a laboratory animal. CVF is known to have an anti-complementary activity which is thought to be responsible for tissue damage limitation.

Famous Quotation: "The degree of ignorance concerning economics in this country is incredible."—Chet Huntley

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University of Cincinnati Medical Center psychiatrists and psychologists have completed a clinical study of the effects of the Buffalo Creek dam disaster in West Virginia more than two years ago. Based partly on the findings of serious psychological impairment, 654 survivors will share in the award of $13.5 million to be paid by the Pittston Company, owners of the dam. Sleep disturbances, especially during rainy or

stormy weather, disorganization of thinking and behavior, anxieties and fear affected many. The study required considerable time because some of the survivors have, understandably, moved away.

The Federal Trade Commission has dismissed a complaint against the 1970 merger of Warner-Lambert Co. and Parke, Davis & Company, ruling that the merger does not restrict competition. The judge characterized the overall competitive situation among drug companies by observing that recently in the ethical drug group no less than 8 firms have ranked within the top 4, while 11 different firms have been within the top 8. Members of Congress sometimes fail to recognize competition but the judge apparently knows what it is.

The incidence of nuclear accidents is difficult to specify, mainly because the 50 or so nuclear power plants operating in the U.S. have not had any accidents. However, a 3,300-page report of a study done by MIT estimates that the likelihood of a disaster from nuclear reactors is not as great as has been thought in the past. The report says that "Non-nuclear accidents to which society is already exposed are about 10,000 times more likely to produce large numbers of injuries to people than nuclear plants." Also, "Nuclear plants are about 100 to 1,000 times less likely to cause costly large dollar value accidents than other sources."

During the past year the 171 VA hospitals recovered about $1.4 million worth of silver and mercury. Recovering mercury is important because the supply is limited. Silver from old x-ray films, from x-ray developing solutions and from exhausted medical-device batteries is salvaged and may be used over and over.

Senator Bill Brock, Tennessee, has introduced a bill to provide a medical expense tax credit to protect against catastrophic medical expenses. His bill would limit a family's ordinary medical outlay to 15% of its income. After that Senator Brock's tax credit "insurance" would pick up 85% of all costs.

Mr. Roudebush reports that the Veterans Administration is leading all other federal agencies in the employment of Vietnam-era veterans. Twelve percent of the VA work force is so classified. There are more than 88,000 veterans of all wars employed by the VA.

California prepaid health plans (PHPs) are reported to be losing more customers than are being enrolled. An audit by the state auditor general has been disputed but when it was first published it indicated that only 48% of PHP income was spent directly for health care costs —the other part (52%) went for administration and profit.

The new president of the American Pharmaceutical Association, Robert C. Johnson, in his inaugural address recently declared: "The battle on drug product selection is nearly over. Even some of the most bitter opponents are privately conceding that pharmacists will select, and in fact are selecting, the brand of a drug to be dispensed. We must now turn our attention to the even more important task of selecting the drug that should appropriately be dispensed." This type of effrontery was predicted at the time the APhA first sought the right to select the brand. Many observers, at that time, thought the APhA leadership was not especially interested in what brand was dispensed—they were, it was predicted, attempting to obtain the right to prescribe the drug—without having taken a history, without having done an examination, and without having been distinguished by an M.D. degree.

Phyllis Schlafly on SPECTRUM suggests that the break-in at the office of that famous unnamed doctor, Daniel Ellsberg's psychiatrist, should have been postponed until PSRO was in effect. When medical records become public it will be difficult to prosecute anyone for invading doctors' offices.

Purdue scientists are apprehensive about the widespread interest in natural or wild foods. Some of the recommended wild plants, such as Indian turnip or Jack-in-the-pulpit, are not edible: they are poisonous. Some edible plants have poisonous lookalikes. Student researchers investigated some 60 commonly growing wild plants this summer and, in the meantime, Purdue advises caution.

Senator Kennedy is chairman of the Senate health subcommittee. He is also chairman of the Congressional Office of Technology Assessment. The OTA has appointed a drug bioequivalency panel to study bioequivalency at the request of Kennedy. The Senator announced recently that bioequivalency is "one of the most complex and difficult health situations." He also announced that his panel had completed its work in three months and had issued a "first-rate" report. This is mighty snappy work for such a complex problem.

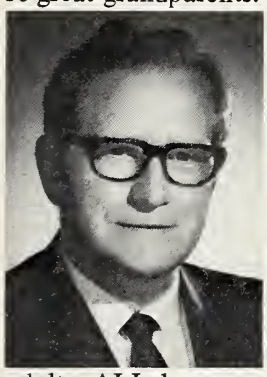
An article in "The Lancet" recently described the finding of high mercury levels in the blood of commercial laboratory technicians engaged in volumetric gas analysis. The hazard was due to faulty technics. The author thought that similar hazards existed in hospital laboratories.

The Marshfield Clinic has found that fabrics labeled "wrinkle free" or "permanent-press" may cause allergic reactions. The irritant is formaldehyde which is released from the fabric when the wearer perspires. Formaldehyde is also present in some shampoos, hand lotions and rubber gloves. ◄

"Through a Child's Eyes"

OTIS R. BOWEN, M.D.
Governor of Indiana

I have found that one of the most personally satisfying experiences that any adult may have is to share intimately in the development of a child. Most of us gain this type of experience at the closest possible range . . . as parents . . . as grandparents . . . and some of us are fortunate enough to be allowed to be great-grandparents.



Others of us find that same satisfaction from within others of our family . . . from perhaps our profession . . . or from our avocations. But as adults, ALL humans at some point in time experience that inner glow of joy that can come only from seeing a child grow into life.

I am certain that there are countless numbers of personal experiences that we can each recall, each of which has a special place in our heart and in our mind.

But I am certain that of these many experiences, there is at least one that runs common among each of us. And that is the experience of seeing the seeds of individual expectations for the future being planted, growing, and maturing as a part of the whole personality.

Through the eyes of a child, all things are possible . . . and most are dead certain sureties.

"What do you want to be when you grow up?" is a question we have all asked, and by way of answer we gain insight into our world . . . a world we find so terribly important . . . as only one who is free of the disappointments of life can see it.

Isn't it amazing how a world so complex, so vexing, and so trouble-filled, can be held in such sharp focus by a growing child?

We listen attentively to their expectations . . . we humor them for their aspirations—and we shield them from the bitter realities of life that lie before them, because we love them—and because we perhaps secretly long for life truly to be as they view it through a child's eyes.

Adolescence is beyond any doubt the most painful period of human development—for both the child and the adult. It is so because they are at a point in their life when the true perceptions of the eye begin to collide with the hopes and aspirations of the heart. And we suffer with them the first experiences of an all-too-common adult emotion —frustration.

Today, in 1974, America is in her adolescence. The bright happy baby born nearly 200 years ago, filled with perhaps more promise than any nation previously conceived, is in the midst of the onset of adolescent awkwardness.

The expectations that came with our birth for all of our people . . . expectations written in magnificent prose in countless documents of human rights, and written in the blood of countless numbers of our patriots on countless numbers of our battlefields, somehow seem to be colliding with a bitter reality that it is not all so easy as we had expected, that somehow successes are fewer . . . are less significant than we had hoped or are more illusive than we had anticipated. And these experiences are bringing about a new emotion of national frustration that glares in on us from seemingly every corner.

And perhaps what makes this dawning sense of frustration all the more troublesome is the fact that we are a nation which has accomplished more technologically than any other nation.

Disease cuts down our number. So we attack it and we bring it to heel.

Man looks at the moon, and wonders what it would be like to step on its surface . . . to trickle its matter through his fingers. So we go there, and we even drive a golf ball over its rocks and rills.

We want mobility. So we make more and finer cars, trains, planes and boats than exist any other place on the globe.

We want shelter. So we construct more and better homes, apartments, buildings and dwelling places than can be found anywhere we know of.

We want food. So, through the genius of our technology, we grow more . . . harvest more . . . preserve more . . . and distribute more of it—in greater variety—than in any other nation in the world.

We are used to success. We have done it before . . . we can do it again. We have a *right* to expect to succeed! This is the attitude that saw us through our childhood.

But, recently, it hasn't gone quite that way. When we began to approach—not technological—but HUMAN problems, we began to experience fewer successes. We found ourselves going back to the social "drawing board" more and more often. And we don't like going

Presented before the annual meeting of the Marion County Medical Society at Indianapolis on Sept. 17, 1974.

back to square one over and over again. Our national irritation shows. Our national frustration mounts. And the shadow of doubt begins to cloud the once-bright horizon of hope.

We don't know whether we have over-expected or whether we have under-produced, when the solution we pursued so vigorously, and applied in such good faith, comes up largely empty handed. We don't know whether the solutions were wrong—or whether our applications were faulty.

I would be a poor speaker, indeed, if I didn't have an answer . . . and I would be less than honest if I were to try to hold out my answer as THE answer, or even the ONLY answer.

Solutions Were Wrong

I believe that we are at fault in BOTH areas. In many instances our experiences are proving that our solutions were the wrong ones to start with. And then we didn't help things because our pursuit of them lacked sincerity, and enthusiasm and support.

The bulk of social solutions we have pursued were born in the era of the great depression and the New Deal. During that period, with the elements, the economy and the international scene all seeming to conspire against us at one time, Americans turned to our federal government out of frustration, and said, in effect, "here, you run the damn thing!"

So we created federal programs and agencies so numerous that we had to refer to them by their initials. We asked government to create. Not to encourage . . . not to foster . . . but to *create*.

And we created jobs. We created money. We created bold new bureaus with impressive statutory and regulatory powers to try to DO what we are having trouble doing ourselves. In the broad stroke, this was our solution.

History shows that we emerged from the depression. We got into a war, but I'll not belabor that old argument. At any rate, we kept on applying the same solutions—to more and more areas, until, perhaps at its height about five to ten years ago, we were declaring "war" on the problems of man with the regularity and ferocity of purpose of a Tartar warlord.

We declared war on pollution. War on poverty. War on housing. War on crime. And we declared war on social injustice. Each declaration was made in all good intent. To back it up, we marshaled a mighty army of federal bureaucrats—and armed them with the most potent weapon of all—the federal regulation.

We marched boldly off to war—and largely we LOST. We didn't lose everything . . . we didn't lose every skirmish, but we didn't do what we set off to do. And, where victories could be counted, largely they came because the people who won them, did so hand-to-hand at the most parochial of levels.

We did accomplish many things. We hauled down the "black" and "white" signs that were posted over public facilities in every corner of our nation. We expanded public rights under the law. We won a host of court battles. We fined a ton of law-breakers. And we penalized a throng of regulation non-conformists.

But all in all, our social crusades have failed the expectations we held for them.

Our economy and our society is regulated, classified, and graded. We are computerized, catalogued, and counted. We have spent enormous amounts of the public's wealth —WILLINGLY—in the honest pursuit of worthy goals. But still we have little to show that might not have been accomplished otherwise.

Six years ago we elected a President who pledged to do something different. One of 1968's most welcomed presidential campaign promises was to reverse this power flow down the Potomac—and take a large measure of it back to the states. The concept was simplicity itself. Why put all your programmatic "eggs" in one basket in Washington, and have only ONE colossal success or failure—when you could put it in FIFTY baskets?

Certainly, there might be 48 failures—or even 50—but the chances of success in at least one, are 50 times better. And then the federal government could be about its proper role of fostering the duplication of that success in more and more instances.

A Start Was Made

We started down that road in 1968. But it was a long and difficult road indeed. Why was it so? Because the people who had to vote the programs and the money for them were largely the same federal philosophers that had been at work for the past four decades. Add to this the inertia of entrenched federal bureaucracy, and you have a hard pull at best. But a start was made. Revenue sharing was the first major example. For the first time, state governments and local governments had funds to apply to state and local problems without having to define those problems into neatly prescribed programmatic and regulatory "boxes."

As a governor, I can tell you how nice it is to be able to spend Indiana's own federally contributed tax dollars in the manner and for the same problems that Indiana spends its STATE generated dollars. And as governor, I can also tell you how nice it WOULD BE if we could go after—say—pollution, in the way we know best how to do it, without having to eat up huge sums of money in doing it the way that Region Five of the Environmental Protection Agency dictates that we do it. Our goals are the same—to get clear skies and clean waters. But how much better it would be if we could get on with that work, rather than creating a massive agency of federally subsidized paper-shufflers —who remove not one speck of matter from the air or the water!

After all, the people who elected me governor wanted me to do something about Indiana's problems of pollution. They wanted me to do

something about poverty. And they wanted me to do something about equality under the law. Because I campaigned for the job, I expressed my willingness to help them. But it gets awfully old to have that role reduced to one of pleading with our General Assembly for additional state match monies for a federally directed program—that changes almost daily in its demands upon the state—which shows more bureaucracy than results.

It is this type of thing that I believe lies at the core of many of the national frustrations that we all see. It is this message of "get the public back in its own business" that I believe is the one that is trying to get through to our two political parties.

By this time, I am confident you are interpreting my remarks as I intended—even though I have not mentioned the words medicine, physician or patient.

We have had too many failures, or at best half successes, in the vast multitude of alphabet programs of the past. Yet our federal government continues to over-plan, to over-regulate and to over-run so much of our lives and so many of our businesses and professions.

I recognize these are times when more rules and regulations are necessary than 100, or even 50, years ago. But the restrictions should be ever-so-cautiously conceived, carefully implemented and constantly re-evaluated for change or discontinuation.

The medical profession has been the target and the recipient of more than its share of curtailment of its freedoms—and all in the guise of better care to more people at a cheaper price. Instead we have seen perhaps a little broader coverage—which is a desirable goal—but accompanied by increased costs, an avalanche of paperwork, harassment by non-professional clerks questioning patients' need for treatment, need for hospitalization, length of hospital stay, type of treatment rendered, and constant doubt cast on fairness of fees charged for services rendered.

Yet more is coming. PSRO, I fear, will be one of the most divisive programs ever created: It will pit doctor against doctor, doctor against hospital, and doctor against reviewing clerks. Besides PSRO, the new health plan bill for 1974 now being discussed by Congress will essentially set up a public service type commission to regulate all phases of the practice of medicine.

What I believe our professional role should be, is to be increasingly aware—and understanding—of the causal motivations which give impetus to increasing public involvement in health care delivery. The public is keenly aware of the potential of a smoothly functioning system of health care delivery—and it desires that the full scope of those services be reasonably accessible to all.

The Public Expects Too Much

We have perhaps increased the public's health care expectations beyond our present delivery capacities because shortage of physicians . . . the maldistribution of those physicians which we do train . . . and the necessary differentiation between health care staffing specialities has kept pace neither with actual scientific advancements nor with the public's perception of the state of the medical art. Perhaps we, as a profession, have been too slow to evolve in our own practices.

Perhaps the rapidly changing social patterns and population shifts from rural to urban . . . from urban to suburban . . . and from the family doctor concept to one of massive specialization, is largely responsible for the evident disparity between service expected—and service delivered.

Perhaps our professional concern for the ultimate direction of American health care actually has its roots in economic soil . . . the spiraling costs of building construction and living . . . the increasing expense of both medical education and medical research—to name but a few possibilities.

But, whatever the actual reason for the increasing pressure for government's growing presence within our health care delivery, our approach should be one based upon expanding the humane practice of medicine as broadly and as reasonably priced as is humanly possible. If we approach this problem as we do a medical problem—by first diagnosing, and then compassionately and effectively treating it—both society and the health care delivery system will be the beneficiaries. But if, through total passive or objectionist attitudes, we fail to deal realistically with this problem of society, the public will speak through their only effective voice—governmental action—and both our profession and society as a whole will suffer.

Much of what will happen within the next few years will depend upon how we as a part of the health care delivery system react. I believe that we must be realists, and we must be open to rational suggestions. We must be activists, and we must be effective and understanding practitioners of the POLITICAL as well as the healing arts.

In order to fully grasp the political implications and in order to discharge our obligations as citizens, it is important to comprehend the range of public issues which have health impact.

There are different ways to become participants in this process, as a private citizen or as a public official. The path which led to the governor's chair started for me from the coroner's office in Marshall County, Indiana. How you become involved, will be based upon many factors . . . your time, your specific interest, your other civic endeavors, your personal "style," to name but a few. There is no standard check list. But once you determine to become involved, once you accept the fact that success and involvement requires the toleration of failure and frustration as well as the exuberance of success, and once you make the commitment to serve the public

well-being as best you can in any role you assume, then you will find that you can participate in a meaningful way.

Well, I think we have matured as a nation to the point that government no longer needs to shield our childlike minds from the reality that we just might not be able to do all that we want—as fast as we want to do it. We no longer need the paternalistic pat on the head that comes from the creation of another brave federal answer.

W are ready for the federal goverment to admit its shortcomings, and for it to be adult enough to allow the public back into its own affairs.

Now I don't know if this type of solution is going to work any better—but I seriously doubt if it could record much more of a history of failures.

We must all seek a reduced amount of national glibness, and exhibit more national involvement and concern. It is because America is built to work only when all of its persons work in its best interests that we must once again involve people in their own affairs.

In this effort we may all learn that it is the child who perceives his world as it truly is. ◄



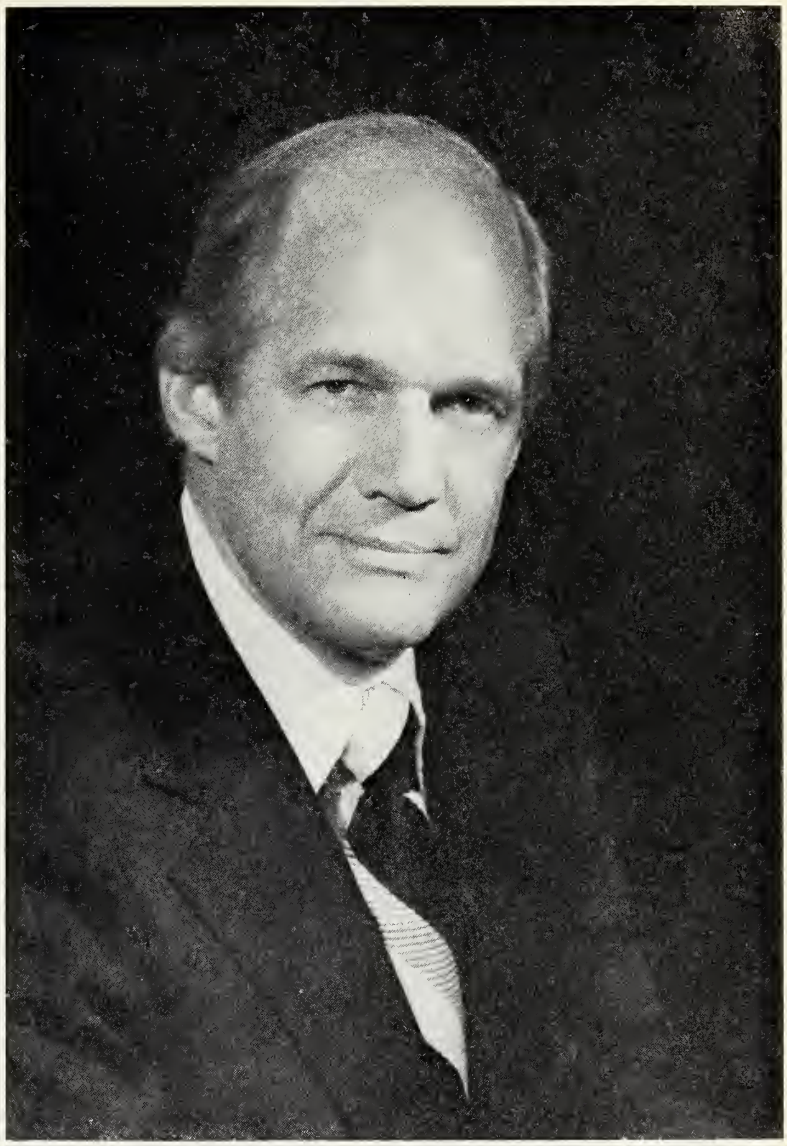
DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Postpuberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250.

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GILBERT M. WILHELMUS, M.D.
President
Indiana State Medical Association
1974-75

Dr. GILBERT M. WILHELMUS, who has occupied the office of president-elect for one year, was elevated to the presidency of the Association during the 125th Annual Convention recently.

Dr. Wilhelmus graduated with the M.D. degree from St. Louis University in 1946 and became a member of the Indiana State Medical Association in 1948 when he began his private practice in Evansville. He has been engaged in family practice since that time. He is a member of the American Academy of Family Practice.

He is past-president of the Deaconess Hospital Medical Staff and is also a member of the medical staff of St. Mary's Hospital.

Dr. Wilhelmus is a specialist in sports medicine and has been active in support of sports in Evansville and throughout the state. He is team physician for Harrison High School, is consulting physician for the athletic program in Evansville high schools, and is a member of the ISMA Sports and Medicine Committee.

He has always been active in his medical societies. He served as secretary of the 1st District Medical Society, and was elected alternate councilor in 1961. He continued in this position until 1968 when he was elected councilor. He then served either as councilor or trustee until 1973. He was chairman of the Board of Trustees in 1972-73, from which position he moved to president-elect.



Report on WAT 21 Audience Survey

SHARON CHENOWETH GREENE
Indianapolis

To borrow a phrase from our friends at the telephone company, "the next best thing to being there" is to see color telecasts of patients, surgery and other clinical presentations on WAT 21 Medical Television.

A recent WAT 21 Audience Survey indicated physicians and allied health professionals are doing just that. WAT 21, operated by Indiana University School of Medicine, provides a unique supplement to conventional means of Continuing Medical Education with its daily color programming to 26 hospitals in seven areas of the state.

Conducted by mail in May of this year, the WAT 21 Audience Survey was distributed to 3,000 health professionals. Thirteen percent responded.

Two thirds of the surveys were direct mailed to M.D.s in counties which have at least one hospital served by WAT 21. The M.D.s surveyed had a 9.7% return rate.

Thirty-five percent of the M.D.s responding indicated they watch one or more programs during a two-week program cycle.

The largest number of M.D.s responding—68%—are in private practice.

Classified by age, doctors in practice from 20 to 30 years responded in the greatest numbers—31%. Those in practice less than 10 years ran a close second with 27% of the response.

Steven C. Beering, M.D., Dean of Indiana University School of Medicine, while discussing the survey results said, "It is most gratifying that fully one third of all practicing physicians in the WAT 21 viewing area (responding to the survey) find the medical television offerings so attractive as to be regular viewers. In addition, about one quarter of Indiana nurses and about one fifth of allied health personnel (responding) appear to be satisfied customers."

"It is encouraging to note that physicians in all age groups are going to the hospital viewing areas to watch WAT 21," observed George T. Lukemeyer, M.D. as he appraised the survey data. "It indicates a good acceptance of the medium."

Dr. Lukemeyer is Executive Associate Dean of the School of Medicine.

"There is growing acceptance of television for Continuing Education; it has an important role to play in the future as one of many means of educating the professional," Dr. Lukemeyer added.

"We're not showing 'home movies' on WAT 21," he emphasized as he continued to correlate the survey data to the quality of Continuing Medical Education programs being produced and telecast by the closed circuit facility. "Color television has an important place in the health professional's Continuing Education as well as in student education."

The major portion of WAT 21 programming is clinical and color is essential to practically any clinical presentation. Pointing out diagnostic features of various disease entities, observing surgical films, looking through the television microscopy unit at slide specimens are but a few examples.

WAT 21 is unique among closed circuit educational television systems in that it is a full color, FCC licensed, broadcast facility. Licensed to "the Trustees of Indiana University," WAT 21 is autonomous. It is operated by the School of Medicine's Medical Educational Resources Program (MERP) and is independent of any other television station or distribution system for its transmissions within a 25-mile radius of Indianapolis.

Specially equipped Indianapolis hospitals receiving WAT 21 broadcasts are Methodist, Winona Memorial, Community, Veterans Administration, Marion County General, St. Francis and St. Vincent.

Lake County hospitals receiving the daily medical programming via WAT 21's sister station, KPD 40,

WAT 21
Medical Television
Audience Survey
Response

	Surveys Mailed	Number Returned	Percent Returned
M.D.s	2,140	208	9.7%
Allied Health	860	185	21.5%
TOTAL Mailing	3,000	393	13 %

Table I

Mrs. Greene is station manager of WAT 21.

at St. John are: Methodist and St. Mary Mercy in Gary; St. Margaret, Hammond; St. Catherine, East Chicago, and Our Lady of Mercy, Dyer.

The WAT 21 signal gets from Indianapolis to KPD 40 and to hospitals in other communities outside Indianapolis via telephone lines leased by the state universities' shared network, the Indiana Higher Education Telecommunications System (IHETS). These hospitals are Howard Community and St. Joseph, Kokomo; St. Elizabeth and Home, Lafayette; Purdue University Student Hospital, West Lafayette; Good Samaritan, Vincennes; Ball Memorial, Muncie; Memorial, Osteopathic, and St. Joseph, South Bend; St. Joseph, Mishawaka, and Bloomington.

"Our goal is to make WAT 21 accessible to every physician in Indiana," said Elmer Friman, director of the Medical Educational Resources Program. "However, full expansion of the network requires careful study of technical and economic feasibilities in each potential location throughout the state. The development of the system has not moved as rapidly as we would have liked it to, but there have been considerable gains since the first Indianapolis broadcast in 1969."

"As the system develops, the Video Cassette Mailing Network has proven to be a valuable service for those hospitals not yet connected to the live network," explained Mr. Friman. "More than 75 hospitals receive video tapes of School of Medicine produced programs and selected programs from outside sources on a free loan basis. Physicians with access to video tape playback equipment can also avail themselves of this service."

WAT 21
VIEWING FREQUENCY
by
Profession

Survey respondents who watch WAT 21	M.D.s	R.N.s*	Allied Health
At least once during a two-week program cycle	35%	22.7%	18.7%
At least once a month	16%	37.9%	28.1%
Several times a year	19%	19.7%	21.9%
Only when there are special programs	30%	19.7%	31.3%

*Registered nurses are listed as a separate category in this table because R.N.s made up 40% of the allied health professionals answering the survey.

Table II

WAT 21's hours of operation are 10 a.m. to 2 p.m., Monday through Friday. The day's programming is repeated to Indianapolis hospitals from 6 p.m. to 10 p.m. Evening hours are available outside Indianapolis subject to the availability of the IHETS network lines. Unfortunately, this availability to WAT 21 is limited and varies with the academic calendar.

Survey respondents indicated the ultimate answer for the greatest utilization of WAT 21 is its availability in the home of every doctor who wants it.

"There is a possibility of medical programming in the home 'after hours' in the future," commented Dr. Lukemeyer. "This, of course, depends on the community's status regarding CATV."

If a doctor subscribes to CATV in a community where the CATV company and the School of Medicine have an agreement for the CATV to carry WAT 21, he can have home viewing by means of a special converter on his conventional TV set. Presently, this is possible only in Lafayette and Kokomo.

"There is always the possibility of doctors' office buildings joining the WAT 21 'network' with equipment like that used at hospitals in areas such as Indianapolis, not yet served by CATV. This would give the private practitioner greater access to WAT 21 during the day," observed Dr. Lukemeyer.

"We're not operating under the illusion that WAT 21 is a panacea," he said, pointing out that "we are eager to hear from viewers. The School of Medicine is most appreciative of the response to the WAT 21 Audience Survey and we invite continued communication from both physicians and allied health professionals." ◄

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Report on Aug. 24-25 Meeting of Board of Trustees

INN OF THE FOURWINDS ON LAKE MONROE WAS SITE of Aug. 24-25 Board meeting. Board members and wives combined business of the Board with some mid-summer pleasure by boating, touring and swimming on Saturday afternoon. The Board had allocated expenses for the meeting to insure that costs of meeting at the Inn would be no more than ordinarily expended for such meeting in Indianapolis.

135,000 TEL-MED TAPE REQUESTS RECEIVED IN HEADQUARTERS OFFICE since inception of statewide telephone health information service. Board discussed the costs of the operation which could come close to $100,000 a year. The system has been financed, thus far, by Indiana Regional Medical Programs, Eli Lilly and Company, and the Association. On recommendation of the Board, Dr. Joe Dukes, president, named Dr. Farquhar, chairman, and Drs. Inlow and Sholty to a special committee to seek ways of financing the program in view of the anticipated demise of the current contributions.

MATTER OF BUILDING EXPANSION TO BE REFERRED TO HOUSE OF DELEGATES without recommendation. Plans presented to the Board call for 10,000 sq. ft., a 16,000 sq.-ft. expansion, or utilization of current building and two adjacent properties already owned by the ISMA, to meet needs of the Association.

MALPRACTICE INSURANCE PLAN FOR ISMA MEMBERS GIVEN GO-AHEAD. Board voted that the Commission on Medical Economics and Insurance proceed to organize a for-profit corporation to institute liability coverage for members.

HEALTH SURVEY BEING MADE WITHOUT SUPPORT AND COOPERATION OF LOCAL MEDICAL SOCIETY brought to the attention of the Board through letter from Orange County Medical Society. The Board passed a motion deploring the solicitation of medical-based data without the collaboration and approval of the county medical society. An additional motion asked that members of the ISMA be requested not to cooperate with surveys unless they are submitted to the county and/or state medical society with the stipulation that the data so collected be available to the local or state society. The Board also took action on the Orange County protest by directing that the Board Liaison Committee with the Indiana University School of Medicine meet with the Dean and others to resolve the problem.

STUDENT GROUP AT INDIANA UNIVERSITY REFERRED TO AS "NADER'S JUNIOR RAIDERS" circulating offensive questionnaires to physicians in the Bloomington area, reported. Motion was passed that the ISMA voice an official protest to the J. Irwin Miller Foundation concerning the activity of the group (IMPERG) and its allegations concerning physicians who did not participate in the survey and that the same protest be lodged with the president of Indiana University. The Board also added the statement that the student group is misrepresenting itself as an academic exercise and is accepting fees illegally.

CONFIDENTIALITY OF PATIENT RECORDS DISCUSSED. Board heard opinion of its legal counsel which said: "While there is no Indiana statute which specifies that hospital records per se are confidential, since most hospital records are composed of physicians' statements based upon their examination or conversation with the patient, such records would be confidential to that extent unless expressly or impliedly waived by the patient. Obviously, the most common form of an express waiver is some document signed by the patient authorizing the bearer of the document to examine hospital records of the patient.

"As we have oftentimes noted in the past, the 'privilege' of revealing medical reports belongs to the patient, not the doctor or hospital. Consequently, any hospital which reveals its patients' records to a third party, absent patient authorization, court order or a precise ascertainment that the patient has impliedly waived the privilege, is subjecting itself to potential liability to the patient for the revelation of such medical records, especially those records prepared by a physician.
In additional conversation on confidentiality, it was reported that patients under Medicaid and Medicare were compelled to sign forms upon hospital admittance granting access to their medical records by hospital personnel. On motion of the Board, both matters are to be brought before the forthcoming joint meeting of executive committees of the Indiana Hospital Association and of the ISMA."

WEST VIRGINIA STATE MEDICAL ASSOCIATION TO PRESS FOR AMENDING PSRO LAW,

OR REPEAL, Dr. Joe Dukes reported. As guest of West Virginia he had attended the Association's meeting. Other actions taken by the Association, he said, included action to require all West Virginia members to be members of the American Medical Association, continued promotion of use of a standard insurance claim form, and encouragement of tax credit for medical care of welfare recipients since physicians are not being paid usual and customary fees under welfare program.

PRAISING THE ISMA-AMA DELEGATION FOR THEIR ACTIVITIES at the June 1974 meeting of the AMA, Dr. Wilhelmus, president-elect, reported the delegation worked hard and there was little question in anyone's mind as to where Indiana stood on the issues, especially PSRO. Dr. Wilhelmus also asked for nominations from each district for the committees and commissions of ISMA. He also reported that working in conjunction with INTRAV he had scheduled three trips for Indiana physicians and wives in 1975, including an African tour, a trip to Brussels with a trip down the Rhine River, and a Holy Land tour.

GRANTED THE COMMISSION ON MEDICAL EDUCATION AND LICENSURE $500 to develop an exhibit on the ISMA accreditation program for the State Convention, October 4 through 8 in Indianapolis.

HOUSE BILL 16204 PROBABLY THE MOST DANGEROUS OF ALL BILLS as far as the medical profession is concerned, reported Al Lerner, AMA field secretary to Indiana. Bill is under consideration in the House Committee on Interstate and Foreign Commerce. Lerner reported to the Board that it was the hope of the chairman of the Committee to "railroad" the bill out of Committee on August 22 but this could not be accomplished because of lack of a quorum. Substance of the bill has been circulated to the officers and trustees of the Association, to presidents and secretaries of county medical societies, and to the Commission on Legislation.

NATIONAL HEALTH INSURANCE COMMITTEE OF THE BOARD FORMULATED to present at each meeting a precise summary and analysis of the current status of this and other national legislative matters. Chairman of the Board Santare named to the Committee Dr. Wilhelmus, chairman, and Drs. Goodman, Ingram, Gosman, Dukes, and himself.

SPECIAL DUES ARRANGEMENT FOR MEMBERS OF THE INDIANA UNIVERSITY SCHOOL OF MEDICINE FACULTY, discussed with referral made to Membership Committee of the ISMA for study and report back to the Board.

BOARD TO RECOMMEND THREE MEMBERS TO THE BOARD OF BLUE SHIELD at the next meeting. Dr. Santare reminded the Board that incumbents are Drs. Glock, McIntosh, and Gutierrez.

PSRO SUPPORT CENTER ACTIVITY REPORTED BY DR. MCINTOSH who said that the support center had been funded by the federal government in the amount of $192,000 and that offices of the Center had been established in Fletcher Park in Indianapolis. Dr. McIntosh said that in view of the fact that the establishment of PSROs throughout the nation was inevitable, he, independently of the ISMA, had taken the personal responsibility to organize one to meet the requirements of the law. He expressed the feeling that it was not a good law but that something had to be done. He said nine members were planned for the Board of the organization—one physician from each of the planned PSRO districts, a doctor of osteopathy, and an at-large member. Dr. McIntosh was interrogated by the Board at length.

ARTICLES OF INCORPORATION OF I-MEDIC CONSIDERED AND PASSED. The corporation would fulfill the actions of the House of Delegates in October 1973, that an "independent corporation to accomplish peer review and quality control" be established. There was considerable discussion on the addition of the phrase at the end of Section F which would have read "again only by permission of the local reviewing body." After considerable debate on this amendment, the Board sustained a motion not to adopt this terminology. It was directed that the articles be forwarded to the ISMA legal counsel for review.

IT WAS A STORMY SESSION AT THE AMERICAN MEDICAL ASSOCIATION'S ANNUAL MEETING, Dr. Lowell Steen, delegate to the AMA, reported. There were 150 resolutions and 50 AMA Board and Committee reports to be considered. Dr. Scamahorn, also a delegate, was applauded for his testimony before the Reference Committee on Indiana's stand against PSRO. Other Hoosier physicians who spoke against PSRO at the day-long hearings were Drs. William F. Blaisdell, Seymour, and David Crane, Bloomington. It took eight hours and fifteen ballots to elect trustees to the AMA Board; in which Dr. Donald E. Wood, Indianapolis, was defeated, which was also a defeat for the Indiana delegation who felt that their hard work would result in his reelection.

APPRECIATION EXPRESSED TO OUTGOING AMA TRUSTEE DONALD E. WOOD, for his contribution to Indiana and American medicine. The Board directed that an appropriate communication be sent to Dr. Wood conveying their thoughts.

ECONOMIC AND FISCAL MATTERS DISCUSSED BY BOARD COMMITTEE CHAIRMAN, DR. ELI GOODMAN, who said that he would have a more complete report at the next meeting but that it was obvious that an increase in dues would be necessary to meet the costs of programs such as Tel-Med, I-MEDIC, and the administrative operation of the headquarters.

AMENDMENTS TO A PRO-

POSED NEW MEDICAL PRACTICE ACT WERE DISCUSSED. On motion of the Board, which passed, the Act is to be presented to the Commission on Legislation for consideration.

USES OF MEDICAL DEFENSE FUND REPORT MADE. Medical-Legal Review Committee had reviewed current utilization of the fund and recommended that the fund henceforth be utilized to pay fees of expert malpractice attorneys to review the work of the physician's attorney. In view of the constitutional changes which would be necessary in this area, the Board moved that this and other recommendations made by the Medical-Legal Review Committee be forwarded to the Commission on Constitution and Bylaws for implementation.

PHYSICAL EXAMINATION FOR TRUCK DRIVERS IN INDIANA CONSIDERED on request of Commission on Public Health. The Commission asked that the Board encourage the Federal Department of Transportation and the Interstate Commerce Commission to include a statement from the appropriate law enforcement agency as a part of the physical examination form for truckers. The statement would include any record of applicant's alcoholism, accidents, narcotic use or psychiatric disorders of record. This statement would be cleared through or issued by the Bureau of Motor Vehicles as a licensure requirement. Motion was made by the Board that the recommendation be adopted but that such statements be retained in the offices of the Bureau of Motor Vehicles. Following discussion, the Board tabled the matter until the next meeting with recommendation that Dr. Wilhelmus confer with Dr. Work, member of the Commission, for more complete information.

USE OF STANDARD INSURANCE FORM IN INDIANA TO BE ENCOURAGED through resolution by the Board to the House of Delegates. ISMA will be encouraged to take every action to accomplish form's use.

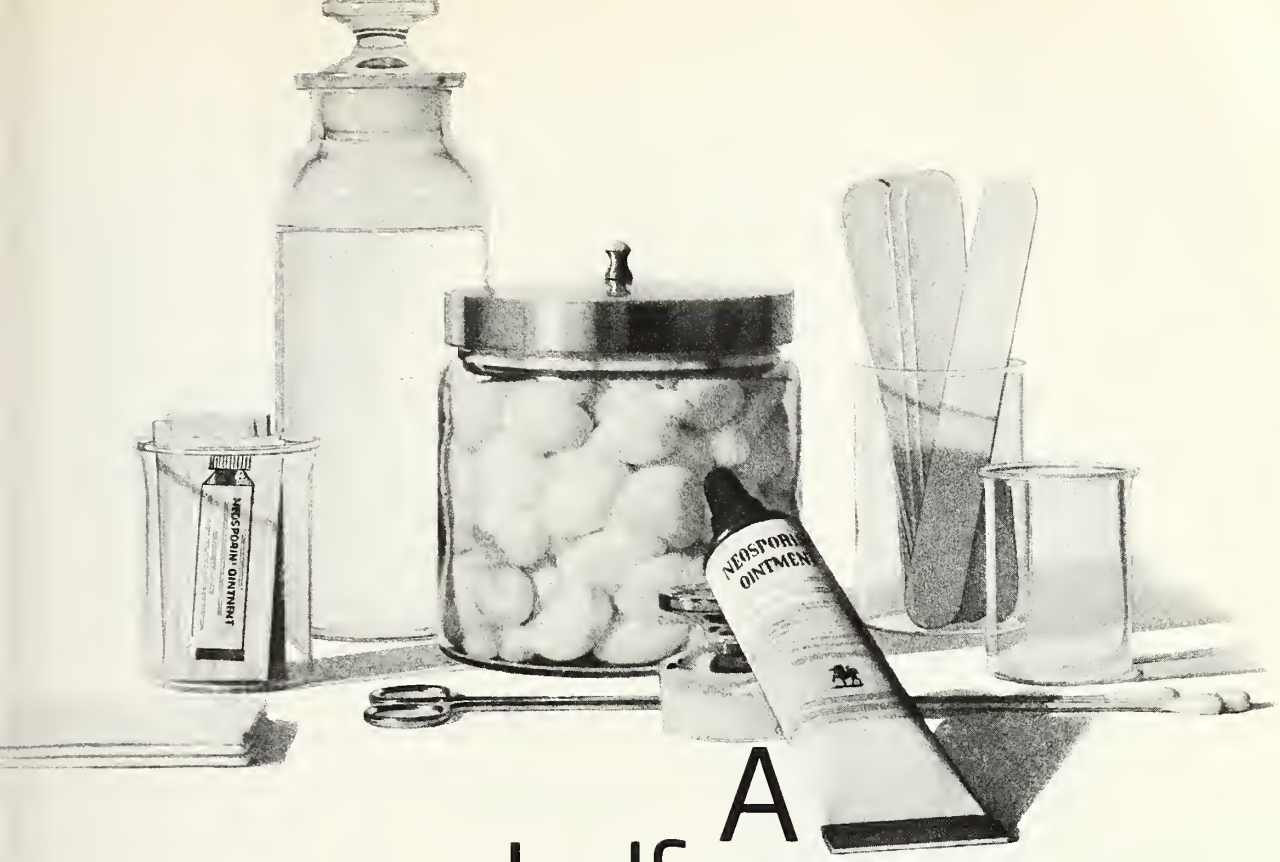
DETAILED REPORT ON ACCOMPLISHMENTS OF GOVERNOR'S EMERGENCY MEDICAL SERVICES COMMISSION given by Dr. John Farquhar, chairman of the Commission. Dr. Farquhar told the Board that the legislature had given the Commission a great deal of power, stating that the Commission should develop quality standards for the entire system of emergency care, have them reviewed by the legislature and promulgated by the Governor, and then set about implementing the system. Describing EMS problems in Indiana, Dr. Farquhar said that they were basic in Indiana and pointed out telemetry was way down the list in priorities. He said the Commission has a report of recommendations for the Governor which was nearly complete.

AMA EMINENCE IN MEDICAL EDUCATION BEING SERIOUSLY THREATENED, Dr. Corcoran advised the group, by three national organizations—the Association of American Colleges, the American Hospital Association, and the National Board of Medical Examiners. Dr. Corcoran is a member of the Council on Health Manpower of the AMA. Dr. Corcoran elaborated on this issue, his concerns about national licensure, and the activity of Comprehensive Health Planning in the state and in the Evansville area. Following discussion of these items, the Board moved that the staff investigate the mechanisms of operation of the A and B agencies (CHP) in Indiana.

WITH 5,500 M.D.s HOLDING LICENSES IN INDIANA, 10 HAVE BEEN CITED by the Board of Medical Registration and Examination. Out of 500 D.O.s they have cited and revoked two licenses. Of 200 podiatrists, two licenses have been revoked; one license of 100 physical therapists; and of the 300 chiropractors, two licenses have been revoked over the past two-year period. Dr. Scamahorn, member of the Examining Board, pointed these figures out in defense of accusations made by some legislators and others that the Board is always "out to get the other practitioners."

VINCENT J. SANTARE, M.D.
Chairman, Board of Trustees

Non-profit hospitals are no longer exempt from the National Labor Relations Act. The new law includes a provision for a 30-day fact-finding period prior to the end of negotiations on contracts. The American Hospital Association had advocated a 60-day cooling-off period beginning at the end of contract negotiations.



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DICATIONS: *Therapeutically,* used as an adjunct to appropriate systemic erapy for topical infections, primary or secondary, due to susceptible organ-ms, as in: • infected burns, skin grafts, surgical incisions, otitis externa primary pyodermas (impetigo, ecthyma, sycosis vulgaris, paronychia) • second-arily infected dermatoses (eczema, herpes, and seborrheic dermatitis) traumatic lesions, inflamed or suppurating as a result of bacterial infection. *Prophylactically,* the ointment may be used to prevent bacterial contamination burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts d wounds accidentally incurred, its use may prevent the development of fection and permit wound healing.

ONTRAINDICATIONS: Not for use in the eyes or external ear canal if the eardrum perforated. This product is contraindicated in those individuals who have own hypersensitivity to any of the components.

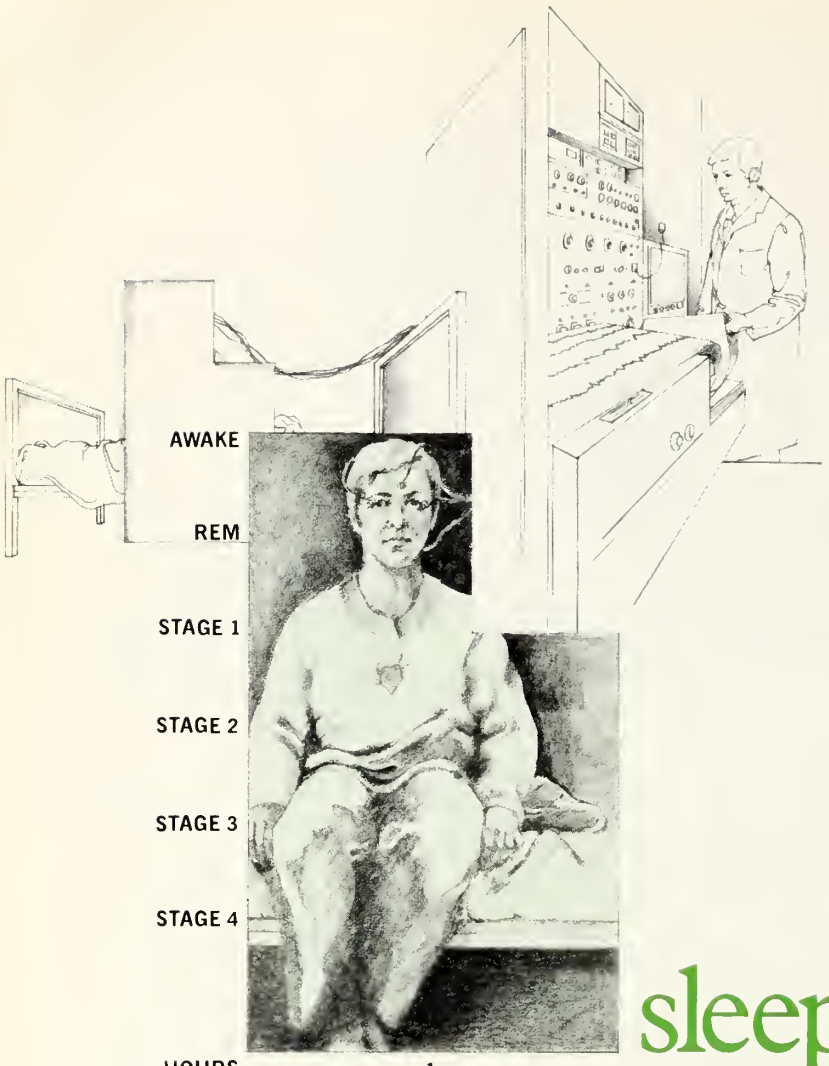
ARNING: Because of the potential hazard of nephrotoxicity and ototoxicity ue to neomycin, care should be exercised when using this product in treating xtensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

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sleep begins within 17 minutes, on average ...

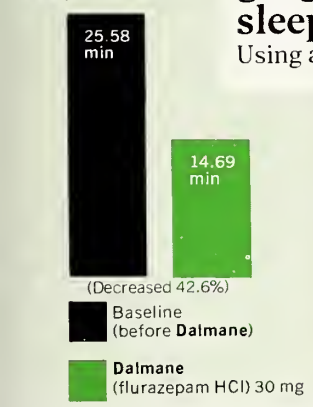
an initial benefit of

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proved by a 22-night clinical study of insomnia patients in the sleep research laboratory and at home[1]

Three insomnia patients selected for difficulty falling asleep were administered Dalmane (flurazepam HCl) 30 mg for 14 consecutive nights. Placebo was given for four nights prior to and four nights after Dalmane. Physiologic tracings on Dalmane nights 1-3 showed sleep induction time averaged 13.90 minutes; on Dalmane nights 12-14, 18.80 minutes. Combined average for the 6 monitored drug nights was 16.35 minutes.[1]



confirmed by clinical studies in four geographically separated sleep research laboratories[2-5]

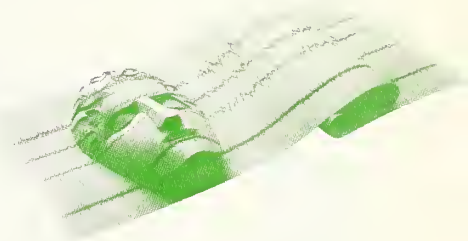
Using a 14-night protocol involving eight insomniac and eight normal subjects, four studies confirmed the sleep-inducing effectiveness of Dalmane (flurazepam HCl) and the reproducibility of this response. On average, one 30-mg capsule induced sleep within 17 minutes. In all these studies, Dalmane induced sleep rapidly, reduced nighttime awakenings, and provided 7 to 8 hours of sleep without repeating dosage.[2-5]

Dalmane (flurazepam HCl) induces and maintains sleep, with relative safety

Dalmane is generally well tolerated; morning "hang-over" has been relatively infrequent. While dizziness, drowsiness, lightheadedness and the like have been noted most often, particularly in the elderly and debilitated, physicians should be aware of the possibility of more serious reactions, as noted below.

Before prescribing Dalmane (flurazepam HCl), please consult Complete Product Information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.
Contraindications: Known hypersensitivity to flurazepam HCl.
Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.
Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.
Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, have also been reported in rare instances.
Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.
Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.



when restful sleep is indicated

Dalmane®
(flurazepam HCl)

One 30-mg capsule *h.s.* — usual adult dosage (15 mg may suffice in some patients).
One 15-mg capsule *h.s.* — initial dosage for elderly or debilitated patients.

- induces sleep within 17 minutes, on average
- reduces nighttime awakenings
- sustains sleep 7 to 8 hours, on average, without repeating dosage

REFERENCES: 1. Kales A, *et al*: *Arch Gen Psychiatry 23:*226-232, Sep 1970
2. Karacan I, Williams RL, Smith JR: The sleep laboratory in the investigation of sleep and sleep disturbances. Scientific exhibit at the 124th annual meeting of the American Psychiatric Association, Washington DC, May 3-7, 1971
3. Frost JD Jr: Data on file, Medical Department, Hoffmann-La Roche Inc, Nutley NJ
4. Vogel GW: Data on file, Medical Department, Hoffmann-La Roche Inc, Nutley NJ
5. Dement WC: Data on file, Medical Department, Hoffmann-La Roche Inc, Nutley NJ

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The Role of the Detail Man

Opinion & Dialogue

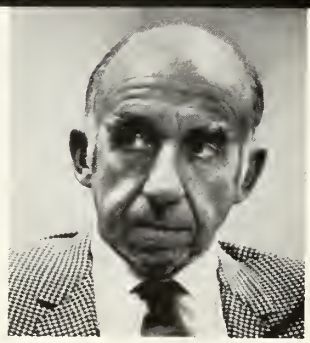


Dr. Willard Gobbell
Family Physician
Encino, California

"I may be prejudiced, but I am very much in favor of the detail men I meet. Most of them are knowledgeable about the drugs they promote and can be a great help in acquainting me with new medication."

Family Physician's Perception

I think that most general practitioners in this area feel as I do about the detail man. Over the years I have gotten to know most of the men who visit me regularly and they in turn have become aware of my particular interests and the nature of my practice. They, therefore, limit their discussion as much as possible to the areas of interest to me. Since I usually see the same representative again in future visits, it is in his best interest to supply me with the most honest, factual, as well as up-to-date inforrnation about his products.



Dr. Jeremiah Stamler
Chairman
Department of Community Health and Preventive Medicine, and Dingman Professor of Cardiology
Northwestern University Medical School

"In the total picture of dealing with health problems in this country there is a potential for detail men to play a meaningful role."

The Positive Influence

My contact with representatives and salesmen of the pharmaceutical industry is the type of contact that people in a medical center, research people, and academic people have and that's in all likelihoo on a somewhat different level from that of the practicing physician.

Let me touch on how I personally perceive the role of the sales representative. These men reach large numbers of health professionals. Thus they could be—and at times actually are—disseminators of useful information. They could consistently serve a real educational function in their ability to discuss their products.

At present they do distribute printed material, brochures and pamphlets—some of it scientifically sound and therefore truly useful—as well as some excellent films produced by the pharmaceutical industry. When they function in this

Is He a Source of Information?

Yes, with certain reservations. The average sales representative has a great fund of information about the drug products he is responsible for. He is usually able to answer most questions fully and intelligently. He can also supply reprints of articles that contain a great deal of information. Here, too, I exercise some caution. I usually accept most of the statements and opinions that I find in the papers and studies which come from the larger teaching facilities. It goes without saying that a physician should also rely on other sources for his information on pharmacology.

Training of Sales Representatives

Ideally, a candidate for the position as a sales representative of a pharmaceutical company should be a graduate pharmacist who has a questioning mind. I don't think this is possible in every case, and so it becomes the responsibility of the pharmaceutical company to train these individuals comprehensively. It is of very great importance that the detail man's knowledge of the product he represents be constantly reviewed as well as updated. This phase of the sales representative's education should be a major responsibility of the medical department of the pharmaceutical company.

I am certain that most of these companies take special care to give their detail men a great deal of information about the products they produce—information about indications, contraindications, side effects and precautions. Yet, although most of the detail men are well informed, some, unfortunately, are not. It might be helpful if sales representatives were reassessed every few years to determine whether or not they are able to fulfill their important function. Incidentally, I feel the same way about periodic assessments of everyone in the health care field, whether they be general practitioners, surgeons or salesmen.

Value of Sampling

I personally am in favor of limited sampling. I do not use sampling in order to perform clinical testing of a drug. I feel that drug testing should rightly be left to the pharmacology researcher and to the large teaching institutions where such testing can be done in a controlled environment.

I do not use samples as a "starter dose" for my patients. I do, however, find samples of drugs to be of value in that they permit me to see what the particular medication looks like. I get to see the various forms of the particular medication at first hand, and if it is in a liquid form I take the time to taste it. In that way I am able to give my patients more complete information about the particular medications that I prescribe for them.

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capacity they are indeed useful; particularly in the fact that they disseminate broadly based educational material and serve not just as "pushers" of their drugs.

The Other Side of the Coin

Obviously, the pharmaceutical companies are not producing all this material as a labor of love—they are in the business of selling products for profit. In this regard the ambitious and improperly motivated sales representative can exert a negative influence on the practicing physician, both by presenting a one-sided picture of his product, and by encouraging the practitioner to depend too heavily on drugs for his total therapy. In these ways, the salesman has often distorted objective reality and undermined his potential role as an educator.

The Industry Responsibility

Since the detail man must be an information resource as well as a representative of his particular pharmaceutical company, he should be carefully selected and thoroughly trained. That training, perforce, must be an ongoing one. There must be a continuing battle within and with the pharmaceutical industry for high quality not only in the selection and training of its sales representatives, but also in the development of all of its promotional and educational material.

The industry must be ready to accept constructive as well as corrective criticism from experts in the field and consumer spokesmen, and be willing to accept independent peer review. The better educated and prepared the salesman is, the more medically accurate his materials, the better off the pharmaceutical industry, health professionals and the public—*i.e.*, the patients—will be.

Physician Responsibility

The practicing physician is in constant need of up-dated information on therapeutics, including drugs. He should and does make use of drug information and answers to specific questions supplied by the pharmaceutical representative. However, that information must not be his main source of continuing education. The practitioner must keep up with what is current by making use of scientific journals, refresher courses, and information received at scientific meetings.

The practicing physician not only has the right, but has the responsibility to demand that the pharmaceutical company and its representatives supply a high level of valid and useful information. I feel certain that if such a high level is demanded by the physician as well as the public, this demand will be met by an alert and concerned pharmaceutical industry.

From my experience, my impression is that sectors of the pharmaceutical industry are indeed ethical. I challenge the industry as a whole to live up to that word in its finest sense.

Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005

P·M·A

The Woman's Auxiliary Reports to ISMA

Dear Doctor:



As I sit and read the ISMA Journal, with all of its interesting subjects, by very knowledgeable people, I feel very humble to be a part of it. Having just reported to your House of Delegates about the Auxiliary year and knowing that the report will be printed in the Journal, I feel it would be very naive for me to write very much at this time.

Every time the Auxiliary meets we repeat our Collect and I have often wondered if our men have ever heard it. I think it will warm your heart to know what we say and pledge and that we mean it sincerely.

"We ask Thee, O God of heaven and earth, to keep us, the helpmates of those whose life work is the ministry of healing. May we learn to know that their sacrifice is not small, but motivates their lives in service to others. Help us to have unselfish, understanding hearts. Keep us patient and forebearing, and as it is given us to keep the hearth of our home fires swept clean of pettiness, so give us strength to be kind and generous in thought at all times."

Warmly,

Beth Bowen

Mrs. Otis R. Bowen
President

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Icy Step

Neither snow nor rain nor heat nor gloom of night ever kept George from delivering the mail at the Jenkins house. But an icy step finally did him in. He skidded, went sprawling, and dislocated his shoulder.

In due course, George filed a damage suit against Jenkins.

"They have a special problem at their house," he pointed out in court. "The roof spills rainwater across the front steps, and in cold weather this creates an unusually slick coating of ice. I didn't know about the situation until after I fell."

This "special problem," which Jenkins did not deny, was held enough basis to establish legal liability. The court said a home owner must take precautions against hazards that a visitor is not likely to notice by himself.

What kind of precautions? Perhaps sprinkling salt or spreading ashes on the ice.

Or perhaps providing adequate lighting. Thus, another home owner was held liable for neglecting to turn on his porch light, after having ordered a taxicab to come to the house at 8 p.m.

True, the cab driver realized that the steps might be icy from an afternoon storm. Still, handicapped by the darkness, he slipped anyhow. And a court later granted his claim for damages. The court said that while the home owner could not be blamed for the ice, he could indeed be blamed for showing so little regard for the cabbie's safety.

But both of these cases involved some degree of fault on the part of the home owner. If he is fault-free, he is generally free from liability as well.

The claimant in another case was a newsboy who slipped while delivering the evening paper. But the visibility was all right and the step he slipped on, though icy, was no worse than the other steps on the block.

Result: no liability. The court said a home owner owed "only that care which an ordinarily prudent person in like circumstances would exercise"—but no more.

A public service feature of the American Bar Association and the Indiana State Bar Association. Written by Will Bernard.

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ABSTRACTS, BOOK REVIEWS

BIOCHEMISTRY OF WOMEN: METHODS FOR CLINICAL INVESTIGATION

A. S. Curry and J. V. Hewitt, CRC Press, Cleveland, 1974; 354 pages with illustrations; $39.95.

This is a book covering primarily the methodology of hormone and enzyme determinations as they apply to the evaluation of the female patient. The 13 chapters include such topics as monitoring the fetus, estrogen determinations, hormones and breast cancer, enzymes and carcinoma, and problems of thyroid analyses and pregnancy. Each chapter has a brief introduction followed by detailed techniques for performing the various procedures. The author of each chapter gives the techniques that he has found most helpful in his laboratory. These are given in sufficient detail that most clinical pathologists or clinical chemists could set up the procedure in their own laboratory. A large number of references (approximately 1,350 in the entire book) are present for those desiring additional information on the techniques given.

A wide variety of methods are discussed. These include such techniques as gas-liquid chromatography, radioimmunoassay, competitive protein binding and fluorimetry.

In general, the book seems to be well written and would be helpful to pathologists or clinical chemists involved in performing these determinations. Even though a section on the interpretation of the laboratory tests is present at the end of each chapter, most clinicians would not be interested in a book, that is primarily of methodology.

ELTON HEATON, M.D.
Madison

BIOCHEMISTRY OF WOMEN: CLINICAL CONCEPTS

A. S. Curry, J. V. Hewitt, CRC Press, Cleveland, 1974; 179 pages with illustrations; $30.00.

This book of 10 chapters written primarily by English authors covers all aspects of endocrinology and biochemistry peculiar to women. It has too much detail for easy reading by one not familiar with the subject, but this, together with the very large number of references, makes it a good reference book. All stages of the female life from the fetus to old age are included.

An excellent chapter covers the biochemistry of infertility. This presents a summary of the clinical conditions associated with infertility and gives in considerable detail the latest laboratory techniques that may be used in making a specific diagnosis. A section on therapy gives methods of treatment that may be used to correct the specific defect indentified.

The menopause is well covered in two chapters. One of these discusses the endocrine changes and laboratory techniques for evaluating them and also general biochemical changes that are present in the menopausal and post-menopausal woman. The other chapter emphasizes the alteration of calcium metabolism that is present during and following the menopause.

The final chapter is a very interesting one on the biochemistry of depression in women. Depression is sometimes associated with the contraceptive pill, pregnancy, pre-menstrual tension, and menopause. This chapter covers some theories of a possible biochemical basis for this condition and discusses possible methods of treatment.

This book would be helpful to any practitioner dealing with the problems of women. This would include not only the gynecologist and general practitioner but also the pathologist responsible for performing the various tests suggested in the book.

ELTON HEATON, M.D.
Madison

ADVANCED FIRST AID & EMERGENCY CARE

Prepared by the American National Red Cross and published by Doubleday & Company, Inc., Garden City, New York; first edition, 1973; 318 pages with 353 illustrations; $2.50 paper cover and $3.95 hardbound.

This textbook is designed for use by persons who are responsible for giving emergency care to the sick and injured. It has 18 chapters which provide the essential information for all first aid and emergency care. The coverage is complete. Many illustrations help the reader to understand the subjects covered. There are chapters on wounds and specific injuries, poisoning and drug abuse, burns and shock and all types of accidents. Even emergency childbirth is well covered.

Needless to say, emergency care is best given under the supervision of qualified physicians. Any care beyond the scope of this book should be rendered by qualified physicians or medical specialists.

The printing and the paper used are both of superior quality. The price is very reasonable. I would like to recommend highly the popular use of this book, particularly for the training of policemen, firemen, emergency squad and rescue squad members, and ambulance attendants.

WEI-PING LOH, M.D.
Gary

WHAT TO DO ABOUT YOUR BRAIN-INJURED CHILD, OR YOUR BRAIN-DAMAGED, MENTALLY RETARDED, MENTALLY DEFICIENT, CEREBRAL-PALSIED, EMOTIONALLY DISTURBED, SPASTIC, FLACCID, RIGID, EPILEPTIC, AUTISTIC, ATHETOID, HYPERACTIVE CHILD

Glenn Doman, Doubleday & Co., Inc., Garden City, N.Y. 1974; 274 pages plus two appendices; $7.95.

This is one of the most unusual books I have ever read—one of the most interesting, the most thought-provoking, and the most hopeful. The title alone is unusual and indicates forcefully the emphasis the author places on breaking with the past in treating all such children. His thesis is that such children should have the *brain* treated, rather than the *body;* but, on the other hand, his central contribution is the development of simple (*but subtle*) ways of reaching the brain via the body. Furthermore, the treatment *per se* is done, or given, by the parents under supervision at varying intervals by the staff of The Institutes for the Achievement of Human Potential, Philadelphia.

Glenn Doman was introduced to this type of patient as assistant chief of the Physical Therapy Department of Temple University Hospital and Medical School, "more than thirty years ago." There he came under the influence of Temple Fay and thereafter developed a consuming interest in the human brain and its functioning through the nervous system.

It is impossible in a short review to do justice to Doman's

methods, both diagnostic and therapeutic, but it should be stated that a basic tenet is that "function determines structure." "Brain injury acts as a barrier to the reception of incoming sensory stimulation . . . just as it may act as a barrier to outgoing motor response. . . . How do you get a stimulus into the brain through a barrier?" There are three ways: "You must increase the stimuli in frequency, intensity and duration."

This is where the parents come in. They are taught practical ways to apply this rule, after the staff of The Institutes had determined where lies the break in the circuit. Their methods of doing this are fascinating and essentially so simple one wonders the old question: Why was this not tried long ago?

In my opinion, any doctor who has much contact with brain-injured children, or *with their parents,* should read this book. He will find it a pleasure to have some of the cobwebs swept from his brain. Parents are supposed to read this, too, but they should be thoroughly warned not to try any of the treatments described without the preliminary evaluation of their child.

A. W. CAVINS, M.D.
Terre Haute

P.S.

Don't be upset by the introduction.

For the doctor who wishes to check further on this matter before buying the book, an article was published in ***JAMA,*** Sept. 17, 1960, Vol. 174, pp. 257-262, entitled "Children With Severe Brain Injuries—Neurological Organization in Terms of Mobility," by Robert Doman, M.D., Eugene B. Spitz, M.D., Philadelphia; Elizabeth Zucman, M.D., Paris; Carl H. Delacato, Ed.D., and Glenn Doman, P.T., Philadelphia.

THE ETHICS OF GENETIC CONTROL—ENDING REPRODUCTIVE ROULETTE

Joseph Fletcher, Anchor Press—Doubleday, Garden City, N.Y., 1974.

Ethics is that discipline which concerns proper human conduct and this book purports to deal with the ethical problems which are arising at a rapid rate due to the burgeoning knowledge in the science of genetics. The author, who is a professor and author from the University of Virginia (of all places), has captioned his six chapters into deceivingly, benignly named sections such as "Some Ideas," "Some Facts," "Some Doubts," and so on. From the "Foreword" by the nobelist Joshua Lederberg to the final chapter called "Some Hopes" it is painfully evident to the reader that Fletcher accepts nothing from those ethicists who feel there is a basic right and wrong but he is firmly in the camp of the so called "teleologists" who regard good only on its consequences. Indeed in the Epilogue or "Author's Note" he states ". . . Hume was correct: There is no way by logic . . . to get from an *is* statement to an *ought* statement." The author propounds very stimulating and provocative material regarding future control of not only quantity but quality of population. It is well at the outset that he states his own ethical creed so that the reader will know what light the author is casting on these problems. In spite of these innate limitations, the author has put forth some really intriguing hypotheses about the role of science in future procreation. Prenatal detection of genetic disorders is already a reality.[1]

Some of the possibilities seem to include extracting an egg from the Fallopian tube, impregnating it in the laboratory with vital semen, and then returning it either to the actual mother's uterus or that of a surrogate—that is, a woman who would merely incubate the fetus until birth. Thus "old-fashioned" coitus is circumvented. Another more futuristic concept is that of "cloning," or using a nucleus from another cell of the same person in place of the nucleus of a fertilizing cell—creating a situation wherein one person is both father and mother to his or her offspring. Far out, yes, but perhaps possible. Another presently unattained concept is that of an artificial womb. The author sketches all of these ideas but, unfortunately, sometimes seems to forget that they do not at this time exist. It is plain to the reader, however, in defense of the author, that much of Western Civilization's ethics will have to be expanded to include new ideas of adultery, the family and the various family roles as traditionally viewed.

The book is mind-expanding and I liked this especially. It makes it useful reading. On the negative side are the polemics for abortion with the author's naively complaisant disregard of the right of defenseless living things to maintain life[2] (What would Albert Schweitzer make of this?), the curiously recurring fallacy of "dismissing by defining" opposing viewpoints, and his apparent inability to see the potential danger of regulation of life by authoritarian fiat. Who in God's world could we trust to regulate who lives and who dies? Didn't Germany try that one a few years ago? In America, Prohibition proved the futility of legislating personal moral decisions.

There are probably some readers of this review who will want to read the book for the precise reasons that I partially condemn it. If so, then I have done well. Those in agreement with me may wish to buy the book in order to know what

Continued

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ethical problems are in store for us. Could the author, therefore, wish for more?

1. Nadler, Henry L., M.D., Prenatal Detection of Genetic Disorders. *Modern Medicine:* 42:17-20, June 24, 1974.
2. *Abortion and Social Justice.* Edited by Thos W. Hilgers, M.D., and Dennis J. Horan, J. D., Sheed and Ward, New York, 1972.

RODNEY A. MANNION, M.D.
LaPorte

TEXTBOOK OF ENDOCRINOLOGY

Robert H. Williams, M.D., W.B. Saunders Co., Philadelphia, fifth edition, 1974; 30 chapters; 1138 pages; 38 contributors (21 new)—12 added chapters with new content; $28.00.

The format of this newest, the fifth, edition resembles its predecessor so closely that one has to take a second look to note that the outside cover is a sort of reddish brown rather than the bright green of its well-thumbed predecessor. The type is smaller and the paper a mite thinner, so that the publishers have succeeded in actually putting more material into a hundred fewer pages. The finished product still weighs a hefty six-plus pounds and measures 7½ x 10½ inches in addition to being well over two inches thick.

The encomiums I gave the fourth edition (*JISMA,* Nov. 1968, p. 1586) leave me deprived of words that would heap extra praise on this present edition! Suffice to say that I proceeded to spot-check topics that were of extra concern to me. Thus: take the pineal organ, pp. 832-840. What a vast accretion of knowledge in a mere half dozen years! This little, 120 mg organ was all but unknown so short a time ago; and now read and ponder and think of what is yet to come! Or, look up the thymus (several references). How recently it was a derivative of the sixth gill pouch, of no known function, "probably a vestigial structure . . . ." And now! Think of the immune system, the T cells and the B cells! And—yet again—think of the coming and ongoing researches that are uncovering facts still shrouded in fantastic speculations!

But why go on? I only envy my younger colleagues who will live to see many succeeding editions each replete with the newest and latest! "WILLIAMS" is still *the* pre-eminent authority in its chosen field and likely to remain such for at least the foreseeable near future. Congratulations to all and sundry.

ARNOLD LIEBERMAN, M.D.
New York City



REVIEW OF MEDICAL PHARMACOLOGY

Frederick H. Meyers, M.D.; Ernest Jawetz, Ph.D., M.D.; Alan Goldfien, M.D., 4th ed., Lange Medical Publications, Los Altos, California, 1974; $10.50.

In the fourth edition of the *Review of Medical Pharmacology,* we have another of the Lange Medical Publications. This one lives up to the outstanding standards achieved by others. It presents the pharmacology of various medical agents in somewhat more detail and presumably with somewhat more objectivity than they are covered in the extremely useful *Physician's Desk Reference.*

The text begins with seven chapters of helpful general information, covering such topics as "Pharmacokinetics and Drug Interactions," "The Clinical Evaluation of Drugs," "Technics of Drug Administration," "Dermatologic Application," "Toxicity of Therapeutic Agents" and "Drug Abuse." It then systematically discusses drugs under systemic headings, such as "Autonomic and Cardiovascular Drugs," "Central Nervous System Drugs," "Systemic Drugs," "Endocrine Drugs" and "Agents Used in the Treatment of Nutritional and Metabolic Derangements," then finishes up with a section on toxicology. The text runs to some 700-plus pages. It utilizes the end papers for such useful information as apothecary equivalents, units of small measurement, and nomograms for determination of body surface area. It is illustrated by various charts and diagrams—not sumptuously, but probably adequately. It is one of the new generation of books with sturdy flexible covers which materially reduce the cost and do not impair the usefulness of the book. It certainly has an adequate index.

The cost of the book is remarkably economical for a medical text, many of which seem to be trying to outdo inflationary trends. The price of this one is only $10.50, and it impresses this reviewer as well worth it. This book is recommended for every practitioner.

W. D. SNIVELY, JR., M.D.
Evansville

PLATELETS AND THROMBOSIS

Sol Sherry, M.D., Alexander Scriabine, M.D., editors, University Park Press, Baltimore; Proceedings of a Physiological Society Symposium Held in Philadelphia Nov. 20-21, 1972; $14.50; 332 pages, with numerous tables, diagrams, references and an excellent index.

The usual couple-dozen-plus experts in this field of hematology have come up with almost a score of crisp, incisive papers exploring the stated topic in real depth.

To me, a trivially exotic question arose as soon as I was privileged to view the outside of this volume. There was a very famous Russian composer of the late Czarist era of precisely the same first and last name! He was one of the famed FIVE greats of that era. As he died in 1915, I wonder whether the present author and editor is a descendant of this shade of Czarist days? The name is quite unusual. To mystify me further: one of the contributors is a lady with a last name of Puszkin: just possibly, a descendant of that great Russian poet?

Leaving such asides in limbo, we can come right to the point. The symposium is an excellent overview of a rapidly expanding branch of hematology. We have come a long way from the statement that "a clot is a clot, is a clot." At the very start we are reminded that there is a "platelet-platelet clot (white thrombus) and a platelet-fibrin clot (red thrombus) in circulating blood." Still, on page 2, our attention is called to the *release reaction*: a secretory process requiring the presence of ionic ca++ as well as ADP. We have come a very long way, indeed, from the days of writing anent "The Function of Calcium" (Dr. A.L., *JAMA*, Vol. 97, #1, p. 15, July 4, 1931) in all of *two* pages!

The paper, binding and printing are excellent. I failed to note any typographical errors. A very worthwhile volume for the hematologist. The G.P. and the Internist might gain some useful knowledge by scanning its pages now and then!

ARNOLD LIEBERMAN, M.D.
New York City

I THINK I CAN

Breisky, W.: Doubleday & Company, Inc., Garden City, N.Y.; 1974.

This is the story of a little girl who suffered massive brain injury because of a cerebrovascular accident. Suddenly, she could no longer talk or see, and she could hardly move. Her father tells her story in a really remarkable and touching account. It begins when the child lies helpless on a hospital bed. It follows her through five years of vigorous daily training. Ultimately, the little girl learns again to crawl, and then to walk. Perhaps one day she may be able to run. Although she was blind after the accident, she now can read. She is in public school, a happy, well-adjusted member of her class.

This is really a story of courage, of a little girl who would not permit herself to be defeated. The author was a *Saturday Evening Post* editor and small-town newspaper publisher before moving to Bermuda in 1968, to manage the Bermuda News Bureau. We are fortunate that Karen had such an accomplished writer to recount her saga. This is not a medical book, of course, but it should appeal to anyone interested in the sagas of triumph of the human spirit.

W. D. SNIVELY, JR., M.D.
Evansville

LABORATORY TESTS FOR THE ASSESSMENT OF NUTRITIONAL STATUS

H. E. Sauberlich, R. P. Dowdy, J. H. Skala, CRC Press, Cleveland; 1974; 136 pp., with illustrations $12.95.

It is only in relatively recent years that most of us have considered using the laboratory for the evaluation of the nutritional status of individuals or groups. This book brings us up to date on conditions associated with deficiencies of vitamins, minerals, proteins and fatty acids. The normal values of each of these is discussed along with the clinical conditions that are associated with a deficiency. Although methods of determination are discussed, this is not a book of methodology.

There are approximately 1,700 references in the book allowing one to follow-up on any specific point of interest. The section on vitamins is particularly interesting and comprehensive.

This book would be of special interest to physician's concerned with evaluating the nutritional status of groups but would also be of interest to any physician faced with the problem of evaluating the nutritional status of an individual and to the pathologist who must perform these determinations and aid in their interpretation.

ELTON HEATON, M.D.
Madison

THE MEDICAL CLINICS OF NORTH AMERICA—ATHEROSCLEROSIS, VOL. 58, NO. 2

Albert E. Meier, editor, W. B. Saunders Co., Philadelphia, 1974; 457 pages; some tables, diagrams and an extensive bibliography; $4.00.

This modestly attired, extraordinarily inexpensive volume gathers the latest authoritative knowledge on a very moot and rapidly expanding topic, namely atherosclerosis. Some two-dozen prestigious authorities, both here and from abroad, combine to make this symposium nigh must reading both for the specialist in the field and (especially) for the family physician anxious to learn the latest.

There is much of relevance said on smoking, cholesterol, CO, principles of diet and drug treatment, the physiology of myocardial infarction, its diagnosis and treatment, etc.

The language is on the medical student level and yet the messages come through loud and clear. The G.P. can take this volume and keep it at his bedside to read at random: when, as and if. The paper, binding and printing are not luxurious but more than adequate. I saw no typos. All in all, the Saunders Company is to be highly commended for making such symposia available to the profession at what must be just cost.

ARNOLD LIEBERMAN, M.D.
New York City

Continued

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ARNOLD H. KAMBLY, M.D.
Psychiatrist-Director

MEDICAL BOOK GUIDE

Gerald L. Swanson, editor, G. K. Hall & Co., Boston, 1974.

Medical Book Guide is what its name implies. It is a monthly volume that describes recently introduced texts in the medical area, worldwide. It consists of monthly bibliographies of books and serials cataloged by The Library of Congress during the preceding month. Each *Guide* includes a cumulative title index within the volume year, as well as an annual cumulation. Books are included, regardless of length, in French and English. Serials include all those cataloged or recataloged in all Western languages.

The Guides contain more information about each publication than is found on a Library of Congress catalog card. Hence, they provide a research tool for professionals in their field, a comprehensive bibliography for scholars and librarians, and a technical aid for library acquisition and processing of new materials.

Medical Book Guide is edited by Gerald L. Swanson and published by G. K. Hall & Co., 70 Lincoln St., Boston. The volume is published once a month. The average number of pages is 117, and the cost is $145 per year. This book would undoubtedly be of primary usefulness to medical libraries.

In evaluating the text, it is interesting to note the sections listed in the table of contents. There is one on how to use the Guide; one on main entries; and there is a subject index; area studies entries; cataloging in publication entries; series entries; and finally, a title index. This publication should be of considerable use to those interested in knowing just what is going on in the field of medical publishing.

W. D. SNIVELY, JR., M.D.
Evansville

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APHASIA: THEORY AND PRACTICE

Selected lectures and papers by Hildred Schuell, edited with an introductory chapter by Luther F. Sies, University Park Press, Baltimore, 1974; $14.50; 300 pages; illustrations and numerous figures.

This volume is a compilation of papers written by a speech therapist for the instruction and edification of the generations to follow. An M.D. will find here very little that is new and thought-provoking. However, the reading is truly smooth and much of the historical background anent Aphasia is sketched in with a deft, smoothly flowing touch.

To me, this volume made a most pleasant evening of browsing. While recalling all the historic names and events much of Auld Lang Syne flowed over long inactive synapses!

The errors are very few and far between. Thus, on page 18, the author meant tectum and *not* tectRum. (The roof has nothing to do with the liquor.) The binding and paper are superb. This lovely compendium is a credit to Dr. Luther F. Sies, who put it together, and to the University Park Press who give so much for relatively so little.

ARNOLD LIEBERMAN, M.D.
New York City

FIBERSCOPY OF GASTRIC DISEASES

Edited by Kenji Tsuneoka, M.D., Tadayoshi Takemoto, M.D., and Sotaro Fukuchi, M.D., University Park Press, Baltimore, 1974; $65.00; 243 pages, 28 color plates plus innumerable x-ray pictures, tables and diagrams.

This 8x12-inch volume has the most luxurious binding, printing and paper make-up I've ever had the privilege of seeing. The editors, aided by a mere handful of associates, have given us about the most complete picture of the stated topic possible! Starting with a description of the rigid gastroscope made by Kussmaul some 100 years ago, they take us step by depicted step up to the present day instruments capable of seeing (and photographing) the entire stomach and then going into the duodenum! They give and make elementary the use of these instruments for biopsies, surgical repairs and what-have-you.

The language is crisp, clear and most concise. And the color plates: ah, the color plates! They have to be seen to be believed.

But *every* G.I. specialist will have this monograph on his shelf. Most M.D.s should peruse this wonderful volume at least once. And—most unequivocally—every hospital library and school will have to have the volume on its shelves. What greater praise can a reviewer give? Congratulations all around.

ARNOLD LIEBERMAN, M.D.
New York City

TRYPANOSOMIASIS AND LEISHMANIASIS

Katherine Elliott Maeve O'Connor and G.E.W. Wolstenholme, editors, Elsevier Scientific Publishing Co., New York, Ciba Foundation Symposium #20, held jointly with the Venezuelan Academy of Sciences at Caracas in 1973.

Some two-dozen experts on Tropical Medicine plus another score of "observers" participated in this symposium dedicated to Dr. E. Tejera and Professor F. Pifano, whose photos grace the frontispiece of this beautifully assembled monograph. In our present era of nagging complaints and doubts, it might be worth observing that this devastating tropical ailment is unknown in our U.S.A. In Africa, we have the dreaded "tsetse fly belt"; in South America, its equivalent. Enormous areas

of these continents are rendered uninhabitable by the stark fact of humans and their flocks being annihilated by the bites of the Glossina flies who thus transmit the deadly parasite infesting them. We may decry the contamination of our environment: still, we simply do not have any reservoir of this dread ailment anymore than we have schistosomiasis and many more of this ilk.

The only cases of Chagas' Disease ever seen by me were in Caracas where my host took me on hospital rounds. In the present volume, we have a long and detailed discussion of the parasite itself and its still unsettled classification; just how it enters the intermediate host and the vagaries of (also still uncertain) dormancy or multiplication; their metabolism and nutrition; the apparent lack of proven, prophylaxis (or) and therapy. One could go on and on! It was news to me, at least, that the disease could progress rapidly to the stage of sleeping sickness and death or could incubate for up to a decade. Arsenicals are our best weapons, especially in the stage before invasion of CNS. The discussion of the cardiac manifestations was of real significance. And—as a last remark—Pentamidine as a single I.M. injection may protect for many months.

All in all: a splendid monograph that (so far) is only of academic interest to M.D.s here in our U.S.A.!

ARNOLD LIEBERMAN, M.D.
New York City

Abstracts from Various Literature, Prepared by AMA

POSTHYPOGLYCEMIC HYPERGLYCEMIA IN DIABETIC CHILDREN

E. Bruck (Children's Hosp., 219 Bryant St., Buffalo, N.Y. 14222) and M. H. MacGillivray
J. Pediatr. 84:672-680 (May) 1974.

Posthypoglycemic hyperglycemia was suspected in eight diabetic children who had excessive glycosuria while taking large doses of insulin. The cases of two brothers with diabetes since infancy are reported as examples. Rapid changes in levels of blood glucose with episodes of hypoglycemia were suspected; therefore, glucose in blood was measured every half hour for 48 hours while the patients received their customary insulin dosage and diet. Urine was collected in two-hourly portions for measurements of glucose and tests for ketones. Hypoglycemic episodes were documented repeatedly. They lasted between 1 and 22 hours, occurred at varying times, and were usually followed by abrupt rises of blood glucose level; blood glucose value often rose or fell by 200 to 300 mg/100 ml within two to four hours. Hyperglycemic phases lasted from several hours postprandial blood glucose values often failed to detect the to several days. Conventional spot tests of urine and fasting or hypoglycemia.

EFFECTIVE USE OF POSITIVE END EXPIRATORY PRESSURE

J. Kolff et al. (Cleveland Clinic, 9500 Euclid Ave, Cleveland 44106)
Am. J. Surg. 127:541-544 (May) 1974

It is essential that postoperative hypoxia be anticipated and discovered prior to the development of dire consequences such as arrhythmias, hypotension, and cardiac arrest. In three cardiac surgical patients and one patient treated with a pressure suit for postoperative intra-abdominal bleeding, arterial hypoxia and diffuse pulmonary infiltration developed as verified by arterial blood gas studies and chest roentgenograms. The application of positive end expiratory pressure should be considered when conventional methods of therapy have produced no improvement in the clinical condition. Patients are ventilated via endotracheal tube or tracheostomy, and positive end expiratory pressure of 5 cm H_2O usually suffices to reverse the pathologic state. This is demonstrated by dramatic improvements in x-ray appearance and blood gas analysis.

EPIDEMIOLOGY OF CORONARY HEART DISEASE AMONG YOUNG ARMY MALES OF WORLD WAR II

Z. Hrubec and W. J. Zukel (Medical Follow-Up Agency, National Academy of Sciences-National Research Council, Washington, D.C. 20418)
Am. Heart J. 87:722-730 (June) 1974

An epidemiologic study was carried out on 1,393 cases of coronary heart disease (CHD) in World War II army men. Factors showing significant ($P<0.005$) association with the development of angina pectoris, coronary insufficiency, myocardial infarction, and death from CHD at this young age were higher systolic and diastolic blood pressure, higher weight and ratio of actual-to-standard weight, aspects of body build as measured by a greater chest circumference, a heavy frame, and being shorter than the matched controls. Other characteristics more prevalent among the coronary cases were geographical residence in the Middle Atlantic States, a higher socioeconomic score, some graduate education, being an officer, being of Jewish religion, and having a blood group A. A significantly lower risk of CHD was found for rural birthplace and previous occupation requiring high physical activity.

CHARCOAL HEMOPERFUSION IN TREATMENT OF FULMINANT HEPATIC FAILURE

B. G. Gazzard et al. (R. Williams, King's College Hosp., Medical School, London)
Lancet 1:1301-1307 (June 29) 1974.

Twenty-two patients with fulminant hepatic failure who deteriorated to grade 4 coma despite full supportive therapy were treated by repeated periods of hemoperfusion through columns containing activated charcoal. The procedure was well-tolerated clinically. Eleven of the patients regained consciousness and ten left hospital. Follow-up liver biopsies in the first three patients at around six months after discharge from hospital showed restitution of the normal lobular architecture. Of the 11 treatment failures, hemorrhage was responsible for death in three, and in six, brain herniation secondary to cerebral edema was an important contributory factor. The column extracted most amino acids from plasma, and during perfusion arterial concentrations of phenylalanine, tyrosine, and methionine (amino acids known to be involved in the pathogenesis of the encephalopathy) fell substantially. The charcoal was coated with biocompatible polymer, and there was no evidence for removal of coagulation factors. The extraction of platelets was below 30% in most instances, and in only two patients was there evidence that bleeding may have been precipitated by the hemoperfusion. These survival figures are to be compared with a previous survival figure of 10% in a series of 92 patients with fulminant hepatic failure and grade 3 or 4 encephalopathy treated by full supportive measures. ◄



TAX TIPS

by LAWRENCE A. JEGEN, III

Mr. Jegen is a profesor af law at Indiana University Indianapalis Law Schaal, specializing in taxatian, business associations and estate planning. Profesor Jegen urges the reader to consult the reader's lawyer befare applying the data in this article to a particular fact situatian.

There are two recent rulings and one court holding which all shareholders of Subchapter S corporations should read.

The first is Rev. Rul. 74-44, 1974-4 IRB 14, and it has been anticipated for quite some time. This ruling concerns the question of whether amounts which are paid as dividends to shareholder-employees of Subchapter S corporations, may be held to be "wages," and thus subject to the FICA, FUTA, and income-withholding provisions of the federal tax laws.

Often, shareholder-employees decide to pay dividends to themselves, rather than salaries, in order for the corporation to avoid the reporting and paying of payroll taxes. Obviously, this would generally not be a problem where the corporation was organized in order to provide the shareholder-employees with the benefits of a corporate retirement plan. But many Subchapter S corporations are not organized for this purpose. In the latter cases, the corporations have been saving taxes and paper work by paying dividends, instead of salaries, to the shareholder-employees. Now, the I.R.S. has ruled, in a case where the shareholder-employees took dividends in lieu of wages, that the dividends may be considered to be wages and, therefore, subject to the FICA, FUTA, and income tax withholding provisions.

You may find comfort from the fact that there is one major decision in which the court held that ". . . officers of a corporation are not compelled to take salaries for the services they render. They may donate their services to the corporation if they choose to do so." That is, the court found that the payments to the officers were dividends and not wages. See *Commissioner v. Gross et al.,* 236 F.2nd 612 (2nd Cir. 1956). However, the I.R.S. has chosen to ignore this decision—so be prepared for I.R.S. attacks in this area.

Now, if you intend, after advice from your lawyer, to follow the above ruling, then be prepared to feel like a ping-pong ball. Because the Tax Court, in *National Underwriters, Inc.,* T. C. Memo. 1974-14, has just held that, where a corporation's earnings come almost entirely from the personal services of the shareholder-employees, the corporation may only deduct for income tax purposes the amounts of salaries which represent reasonable compensation to the shareholder-employees. Combine this holding with a fairly recent holding of the Court of Claims (*McCandless File Service v. U.S.,* 422 F.2d 1336, in which the court held that even where the entire salary payment is reasonable, a portion of the payment may nevertheless be treated as dividends to shareholder-employees) and you have the beginning of an undesirable game.

Finally, most of you know by now that a shareholder-employee (i.e., a corporate employee who actually or constructively owns 5% or more of the outstanding shares of the corporation) of a Subchapter S corporation may have to include in his gross income an amount of the corporation's deductible contribution which the corporation makes on the employee's behalf to the corporate retirement plan. Specifically, the employee must include the amount of the contribution which exceeds the lesser of 10% of the employee's compensation or $2,500. However, the excess contribution is treated as an employee contribution for most other tax purposes—e.g., income taxation of distributions from the retirement trust, and estate and gift taxation of transfers of the employee's interest in the trust.

Thus, it is not surprising that some employees have taken the position that the excess contributions may be treated by the employees as withdrawals of voluntary contributions—with no adverse affect on the qualification of the plan and trust. Unfortunately, the I.R.S. has ruled that the excess contributions *are* treated as employer contributions for this purpose, and thus, in the case of pension plans, the plan and trust may become disqualified by such employee withdrawals. You might tell your accountant and actuary to read Rev. Rul. 73-533, 1973-49 IRB 11 for further amplification. ◄

Help speed your patient's claim for Social Security disability benefits by **objectively** reporting relevant data—symptoms, signs, positive physical, x-ray and laboratory findings. In each case, dates are paramount in establishing when an impairment began, when its severity was manifested and also how long it is expected to last.

FUTURE MEETINGS, SEMINARS, COURSES

Set Cancer Seminars at South Bend

Cancer Seminars conducted by the Department of Medical Education, Memorial Hospital of South Bend, will be on the second Wednesday of each month up to and including April. The subjects are Cancer of Colon on November 13, Diagnosis of Cancer on December 11, Chemotherapy on January 8, Thyroid Disease on February 12, Leukemia on March 12 and Cancer of the Lung on April 9. A distinguished faculty, composed of authorities from clinical centers famous for treatment of the specific malignancies, will conduct the program from 1 to 4:30 p.m. each day. The individual programs are acceptable for three prescribed hours by the AAFP and the AMA. Correspond with Dr. Wallace S. Tirman, Memorial Hospital, South Bend.

Pediatric Behavior Conference Set

A Pediatric Behavior Management Conference will be conducted at the University of Miami School of Medicine on Feb. 21 and 22, 1975. For information on fee, program site and registration write the Division of Continuing Education, P.O. Box 520875, Biscayne Annex, Miami 33152 or telephone (305) 547-6716.

Cancer Symposium in Florida

The First Annual Cancer Symposium at Walt Disney World will be conducted at the Contemporary Resort Hotel, Lake Buena Vista, Florida, Feb. 19 to 22, 1975. The program is approved for 9½ hours credit by the AAFP. For copy of program and all details write American Cancer Society, Orange County Unit, 132 E. Colonial Drive, Orlando, Fla. 32801.

Meeting Scheduled for Disney World

The Institute for Continuing Education is sponsoring the 20th Central Florida Medical Meeting with The Orange County Medical Society at the Contemporary Resort Hotel, Disney World, Orlando, on January 29 to February 1. The Florida Academy of Family Physicians is cooperating. For details write the Institute at PO Box 11083, Richmond, Va. 23230.

Radiology Conference at Aspen

The Fifth Annual Aspen Radiology Conference will be held March 3 to 7, 1975, at the Aspen Institute for Humanistic Studies, Aspen, Colorado. The meeting will explore the impact of clinical and technological advances on radiologic practice. For more information write Dr. Maurice O'Connor, Denver General Hospital, Denver 80204.

From THE JOURNAL 50 Years Ago

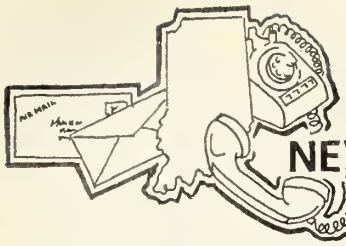
The state of Indiana is possessed of a new health asset since, on October 7, 1924, it came into control of the completed first three units of the James Whitcomb Riley Memorial Hospital for Children. In this hospital, which was dedicated on the seventy-fifth birthday anniversary of the beloved Hoosier poet of childhood, sick and crippled children of Indiana will be brought into health and strength, to face a future that is bright with hope, to become sturdy men and women of the future. . . .

The idea of the Riley Hospital for Children was born in the mind of Dr. Lafayette Page . . . .

Due to the experience and foresight of Dr. Samuel E. Smith, provost of Indiana University, the Riley Hospital for Children will serve the future generations of the state as long as the government of Indiana endures. The law, which was written by Dr. Smith, provides for permanent maintenance of the hospital without the necessity of the institution's managers going before the legislature each two years to pray for an appropriation.

The administration of the Riley Hospital is entrusted to the medical department of Indiana University, Dr. Samuel E. Smith . . . is the supervising head of the institution, and Robert E. Neff, administrator of the Robert W. Long Hospital and registrar of the . . . School of Medicine, is administrator of the Riley Hospital. A committee, composed of Drs. Lafayette Page, John H. Oliver and John F. Barnhill, has been appointed to make recommendations on the selection of the hospital's staff of physicians and surgeons. Miss Veronica Stapleton . . . is superintendent of nurses at the Riley Hospital.

Indiana has reason to be proud of her accomplishment in the building of the Riley Hospital for Children. The medical profession has reason to be proud of the prominent part that has been taken by its own members in the inception of the Riley Hospital idea and in carrying through to success the plans that have furnished Indiana with the finest institution of its kind in America. . . . "The Riley Hospital for Children," **JISMA**, November 1924.



Dr. Vincent J. Santare Named President-Elect



Dr. Vincent J. Santare, Munster, was chosen president-elect of the Indiana State Medical Association at the 125th annual convention in October. During the past year Dr. Santare has served as chairman of the Board of Trustees, on which he has represented the 10th District since 1968. He has also served as delegate and as president of the Lake County Medical Society. In 1972 he served on the Student Loan Committee and, since 1972, on the Executive Committee.

A graduate of the Long Island Medical College (now State University of New York Downstate Medical Center, New York-Brooklyn), Dr. Santare interned at Long Island College Hospital and was certified by the American Board of Urology.

Dr. Santare has served as president of the medical staff of St. Margaret Hospital, Hammond, and as treasurer of the combined United Funds for his area for a number of years. In 1966 he was named "Volunteer of the Year." He is currently treasurer of the Northwest Indiana Comprehensive Health Planning Council.

Dr. Santare resides in Munster with his wife, Joan, and their six children.

Receives Two National Appointments

Dr. John A. Bowman, Kokomo, medical director of the Regional Medical Health Center, Howard Community Hospital, has received two appointments to national organizations.

The Joint Commission on Hospital Accreditation, Mental Health Division, has appointed him to serve on an advisory committee for drafting standards of accreditation for mental health centers.

Also, Dr. Bowman has been appointed as a consultant with the National Institute of Mental Health of the Department of Health, Education, and Welfare. He will serve as a review consultant for mental health center programs and services in states other than Indiana.

Doctors Have Speaking Engagements Throughout State; Subjects Varied

Lay as well as professional and paramedical audiences have heard talks by Hoosier physicians recently, as follows:

Dr. James Botkin, Marion—High Blood Pressure—Marion Rotary Club.

Dr. Frederic Spencer, Vincennes—Foursquare Church, Vincennes.

Dr. John K. Dyer, Fort Wayne—Lutheran Hospital Nurses Alumnae.

Dr. Francis B. Warrick, Richmond—Indiana Association of Sanitarians.

Dr. James K. Fink, South Bend—Emphysema: The Facts—American Lung Association of North Central Indiana.

Dr. E. Wade Adams, Fort Wayne—Mothers of Twins Club.

Dr. Victor H. Muller, Indianapolis—Changes in Blood Banking—Terre Haute Community Blood Program, a United Way agency.

Dr. David C. Brandes, Marion—Howard County Diabetes Association, Kokomo.

Dr. Milton Gibson, South Bend—Kosciusko Community Hospital Auxiliary, Warsaw.

Dr. Barbara J. Krueger, Huntington—Business and Professional Women's Club, Huntington.

Dr. Alfred Wick, Fort Wayne—Diabetics: Insight Concerning the Eye—Fort Wayne Diabetes Association.

Dr. John D. Pulcini, Evansville—Graduation ceremonies at Evansville-Vanderburgh school system's health occupations center.

Dr. William A. Stark, Michigan City—Total Knee Surgery—St. Anthony Hospital Nurses Co-op Educational group—Michigan City.

Dr. George M. Underwood, Lafayette—Family Practice: How Do You Get There?—Medical Students Family Practice Club, Indianapolis.

Dr. Robert Dormire, Fort Wayne—Graduation ceremonies at Parkview Hospital's School of Radiologic Technology, Fort Wayne.

Dr. John L. Horvath, Jr., Lafayette—Tippecanoe County Unit of the American Cancer Society.

Hospital Medical Staffs Chosen

New officers for the medical staffs of the following hospitals have been named recently:

Union Hospital, Terre Haute—**Dr. H. L. Keffer,** chief of staff; **Dr. Marion Connerley,** vice president; **Dr. Fred McCrea,** president, and **Dr. Paul Davis,** treasurer.

Lutheran Hospital, Fort Wayne—**Dr. Allen Aldred,** president; **Dr. Alan Richards,** president-elect; **Dr. James S. Hill,** secretary; **Dr. Joseph Hoover,** treasurer. Additional members of the executive committee are: **Drs. Fred Dahling, Theodore Beutler, Don E. Miller and B. Trent Cooper.**

Dr. Loh Honored Twice

Dr. W. P. Loh, Gary, was recently elected vice-president of Phi Tau Phi Scholastic Honor Society. The society was founded 53 years ago in China and has an international membership. Dr. Loh has also been chosen for inclusion in the 38th edition of *Who's Who in America.*

Two Serve as Parade Grand Marshals

Drs. L. Z. Bunker and George W. Seward, North Manchester, served as co-grand marshals for their community's Fun Festival Parade recently. They were selected "in appreciation of their past deeds while focusing on the community's future needs." The Chamber of Commerce of North Manchester is endeavoring to recruit at least two medical doctors, the retirement of Doctor Bunker and death of Dr. George Balsbaugh last year having left the community short of physicians.

Receives Highest Scottish Rite Honor

Dr. John R. Dragoo, Wabash, was one of 20 Hoosiers honored at the national Scottish Rite convention at Atlantic City on September 26, when the 33rd degree was conferred "because of outstanding contributions to Freemasonry or for significant service to others reflecting credit on the Fraternity."

Eight Medical Assistants Certified

A record number of medical assistants passed the annual Certification examination recently. Among the 540 successful candidates were 8 from Indiana. Cynthia S. Calhoun, Glenda A. Collins and Kathryn A. Kijovsky, Indianapolis; Joanna A. Kline, Huntington, Mildred F. Link, Fort Wayne, and Judith A. Price, Fort Wayne were certified in the Administrative and Clinical category. Loretta G. Cravens and Edna J. Holsapple, both of Indianapolis, were certified in the Administrative category.

Roerig Offers Acupuncture Film

The Roerig Division of Pfizer Pharmaceuticals offers a training film on acupuncture. It consists of a two-part, 45-minute film version of a two-hour symposium. Applications should be made to the local Roerig service representative or Roerig Marketing, Pfizer Pharmaceuticals, New York City.

Poison Data Available

The Hartford Insurance Group offers information for emergency situations involving poisons. The computer information system researches data on chemical toxicity and is available to all Hartford industrial clients. "TOXLINE" is used to denote the system which includes the National Library of Medicine. The data bank stores data on adverse effects of poisoning by drugs, hazardous household, agricultural and industrial products and environmental pollutants, including occupationally hazardous chemicals.

AAP Says Retarded Children Need Athletic Activities

The American Academy of Pediatrics has issued a statement concerning the necessity of providing facilities and opportunities for exercising and for participation in athletics for retarded children. The tendency is to exclude retarded children from such activities. This causes them to be physically unfit, to have poor coordination and to tend to be obese. Their intellectual and emotional development suffer from their poor physical status. The Academy's journal, *Pediatrics,* lists guidelines for establishing proper programs.

Dr. George E. Moses Honored

In Appreciation Day ceremonies at the Worthington High School gymnasium on September 28, **Dr. George E. Moses** was greeted, honored and paid tribute to by many persons in the town and county for his past and present medical service.

Additionally, the Lions Club set up a fund in honor of Dr. Moses and contributions to the fund will be used to purchase equipment for the emergency room at Greene General Hospital at Linton.

Hospital Medical Director Appointed

Dr. Richard Rahdert, a child psychiatrist at the Arnett Clinic, Lafayette, has been named medical director of Wabash Valley Hospital Mental Health Center, Inc. In practice at Lafayette

Continued

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since 1971, Dr. Rahdert will be in charge of operation of the soon-to-be-opened Comprehensive Mental Health Center at Lafayette.

AAFP Honors Dr. Jack Hall

The American Academy of Family Physicians last month awarded its highest award for non-members, the certificate of meritorious service, to Indianapolis internist **Dr. Jack H. Hall.** He was nominated for creating a graduate program in family practice at Methodist Hospital, where he is vice president of medical education at the Graduate Medical Center.

Aesculapian Society Elects Officers

Dr. Wilbert Washington has been named president of the Aesculapian Medical Society. Other officers include **Dr. John Joyner,** vice-president; **Dr. John T. Young,** secretary, and **Dr. Roscoe Henderson,** treasurer. **Dr. Oliver Page** was appointed chairman of the Scientific Committee. All are of Indianapolis.

Three Physicians Appointed To Teach at School of Nursing

Three new adjunct professors have been named to the staff of the University of Evansville School of Nursing. They are Dr. Norman R. Marquis, principal investigator for the biochemistry department of Mead Johnson Research Center; **Dr. Roger E. Newton,** medical director for Evansville Planned Parenthood, and **Dr. E. Gregg Sheehan,** a former president of the medical staff of Welborn Baptist Hospital.

Named to Liaison Committee

Dr. Patrick J. V. Corcoran, Evansville, was recently named a member of the Liaison Committee on Medical Education, the accrediting body for all American and Canadian medical schools. Of the committee's twelve members, six are appointed by the AMA and six by the Association of American Medical Colleges.

Appointed Vigo County Health Officer

Dr. Robert A. Schumaker, Terre Haute, has been appointed Vigo County Health Officer. He succeeds **Dr. Hubert T. Goodman,** who retired several months ago but continued to serve while the search for his successor continued.

Participate in Workshop

Drs. Donald Pell and Anthony Dowell, Muncie, were participants in a recent workshop for area nurses sponsored by Indiana University East and the American Lung Association of Indiana, East Central Affiliate, at Reid Memorial Hospital, Richmond.

Dr. Neher Appointed Hospital Head

Dr. John L. Neher, South Bend, has been named acting superintendent of the Northern Indiana State Hospital and Developmental Disabilities Center.

Heads All Non-Bed Care for VA Hospitals

Dr. Edgar A. Reed, who formerly practiced at Warsaw, has been appointed to head all non-bed care at the Veterans Administration's 171 hospitals and 41 outpatient clinics. A 1957 graduate of the Indiana University School of Medicine, Dr. Reed's new title is Deputy Assistant Chief Medical Director for Ambulatory Care.

Health, Safety Chairman for Scouts

Dr. J. P. Scherschel, Bedford, served as Health and Safety chairman for the 1974 Boy Scout Camporee held in October. Twelve hundred scouts from 200 troops in southern Indiana attended the three-day session at Camp Atterbury.

Named to County Health Board

Dr. Destry Lambert, Tipton, has been named to the Tipton County Health Board to complete the unexpired term of **Dr. Jean Carter,** who became the county's health officer upon the death of **Dr. William Kurtz** on September 6.

Patents Unique Open-Eyed Needle

Dr. Nicholas G. Herr, a Los Angeles plastic surgeon, has patented an entirely new type of needle, described as "open-eyed" and "hollow," for use in surgery and in industry. It was devised originally to safely speed up the time of open-heart operations. It is now being incorporated into a fully automated surgical sewing machine and, with minor modifications, is said to be suitable for textile and shoemaking equipment. Thread breakage is minimized and the machine will run faster and more efficiently with the new needle than with conventional needles.

"Anaerobic Infections" Film Offered

Upjohn announces a medical teaching film "Anaerobic Infections." It is full-color, sound, 16 mm, 20 minutes in length and discusses and demonstrates the proper technics of diagnosis, bacterial identification, and treatment. It is available on free-loan basis. Contact an Upjohn representative or write or call Upjohn at Kalamazoo, Mich. 49001, (616) 382-4000.

Due-Process Provisions Expanded

The Joint Commission on Accreditation of Hospitals' Board of Commissioners has expanded due-process provisions for physicians employed by hospitals in medical-administrative positions. Under the new policy, a physician or dentist who is being terminated has the right to a hearing before a joint conference of hospital governing board representatives and representatives selected by the voting members of the medical staff. The change in the interpretive material of Standard VIII of the "Governing Body Management" Section of the JCAH *Accreditation Manual for Hospitals,* is expected to restrict arbitrary action in the termination of salaried chiefs of services and other physicians in medical-administrative positions.

Congressman Hudnut Wants Commission To Study Medical Malpractice Problem

Congressman Bill Hudnut is co-sponsoring legislation to establish a commission to study the problem of medical malpractice. The press release mentions the problems of excessive settlements and the necessity for higher medical fees as the result of higher insurance premiums to cover higher and higher settlements. Mr. Hudnut also mentions the possibility of premature retirement of doctors because of high costs of insurance and inability to obtain any insurance.

New TV Health Series Premieres Wed., Nov. 20

"Feeling Good" is a new TV health series for adults that is created and produced by the Future Works Division of the Children's Television Workshop. It premieres Wed., Nov. 20, appears on a weekly basis during prime time and will be seen on 250 stations. The hour will probably be 7 p.m., Central time, with a repeat planned for Saturday at 6 p.m., Central time. Extensive consultation with some 300 health experts has produced a list of eleven priority topics. They are: Alcohol Abuse, Cancer, Child Care, Dental Care, Exercise, Heart Disease, The Health Care Delivery System, High Blood Pressure, Mental Health, Nutrition and Prenatal Care.

New Members

The Journal welcomes the following new members of the Indiana State Medical Association and of the county society indicated:

BARTHOLOMEW-BROWN
C. O. Weddle, M.D., 2756 25th St., Columbus 47201

DAVIESS-MARTIN
Robert L. Heymann, M.D., 1400 Grande Ave., Washington 47501

DUBOIS
Wenceslao G. Magbag, M.D., Lin St., Corner of 1st, Holland 47541

FORT WAYNE
David A. Sorg, M.D., 2325 Santa Rosa Drive, Fort Wayne 46805

HENDRICKS
William A. Edwards, M.D., P.O. Box 188, Pittsboro 46167

LAKE
Jamie J. Cebedo, M.D., 540 Tyler St., Gary 46402

MARION
William S. Bennett, Jr., M.D., 1815 N. Capitol Ave., Indianapolis 46202 (ANES)
Edward B. Fitzgerald, M.D., 8402 Harcourt Road, #411, Indianapolis 46260 (TS)
William M. Gilkison, M.D., 8245 South Madison, Greenwood 46142 (FP)
James A. Hunt, M.D., Larue Carter Hospital, Indianapolis 46202 (P)
C. William Johnson, M.D., I. U. Medical Center, Indianapolis 46202 (OTO)
Gerald T. Keener, Jr., M.D., 5455 N. Pennsylvania St., Indianapolis 46220 (OPH)
Clyde B. Kernek, M.D., 8402 Harcourt Road #809, Indianapolis 46260 (ORS)
Robert D. McQuiston, M.D., 20 N. Meridian St., Indianapolis 46204 (OTO)
Tjien O. Oei, M.D., I. U. Medical Center, Indianapolis 46202 (PATH)
Jose G. Panszi, M.D., 960 Locke Street, Indianapolis 46202 (N)
Barton J. Rusk, M.D., 8402 Harcourt Road, #801, Indianapolis 46260 (PUD)
R. K. Silbert, M.D., 3351 N. Meridian Street, Indianapolis 46208 (PMR)
Malcolm S. Snell, M.D., Indiana University Med. Center, Indianapolis 46202 (NS)
Howard H. Wong, M.D., 1800 N. Meridian Street, Indianapolis 46202 (R)
William K. McGarvey, M.D., 8402 Harcourt Road, #208, Indianapolis 46260 (OTO)

MARSHALL
Drew A. Kovach, M.D., 530 North Michigan, Argos 46501

MORGAN
Stephen L. Hardin, M.D., Lynn Road R.R. #3, Martinsville 46151

OWEN-MONROE
John S. Schechter, M.D., 413 W. First St., Bloomington 47401

PARKE-VERMILLION
George Alexandrescu, M.D., R.R. #3, Clinton 47842

PORTER
Maria O. Sacris, M.D., 802 LaPorte Ave., Valparaiso 46383

ST. JOSEPH
Christopher S. Norborg, M.D., 719 North Main St., South Bend 46601
John T. Chan, M.D., P.O. Box 625, Mishawaka 46544

SULLIVAN
Robert A. McCardle, M.D., 777 North Wolfenberger, Sullivan 47882. ◄

About Our Cover

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"I dropped out of the rat race a couple of years ago—what are my chances of getting back in?"

INDIANA STATE BOARD OF HEALTH

MONTHLY REPORT—September 1974

Disease	Sept. 1974	Aug. 1974	July 1974	Sept. 1973	Sept. 1972
Animal Bites	894	1251	1108	1122	1400
Chickenpox	53	69	73	46	51
Conjunctivitis	140	173	187	317	207
Diphtheria	0	0	0	0	0
Dysentery, Unspecified	101	117	79	188	34
Gonorrhea	1163	1838	956	1245	1289
Impetigo	252	182	188	434	316
Infectious Hepatitis	44	73	58	61	72
Infectious Mononuclesosis	68	52	36	89	211
Influenza	2546	2933	2345	2298	2840
Measles					
Rubeola	17	14	10	24	13
Rubella	41	49	26	18	33
Meningococcic Meningitis	2	3	1	1	0
Meningitis, Other	8	7	2	4	2
Mumps	21	34	46	48	32
Pertussis (Whooping Cough)	3	10	4	8	32
Pneumonia	290	515	270	419	352
Poliomyelitis	0	0	0	1	0
Streptococcal Infections	1007	1175	897	1176	870
Syphilis					
Primary & Secondary	10	29	10	36	22
All Other Syphilis	109	122	76	125	89
Tinea Capitis	11	7	12	17	8
Tuberculosis (Active)	31	74	28	60	86

STATEMENT OF OWNERSHIP, MANAGEMENT AND CIRCULATION (Act of August 12, 1970: Section 3685. Title 39. United States Code).

1. Title of Publication: THE JOURNAL of the Indiana State Medical Association.

2. Date of Filing: September 30, 1974.

3. Frequency of issue: Monthly.

4. Location of known office of publication: 3935 N. Meridian St., Indianapolis, Indiana 46208—Marion County.

5. Location of the headquarters or general business offices of the publishers: 3935 N. Meridian St., Indianapolis, Indiana 46208.

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7. Owner (If owned by a corporaton, its name and address must be stated and also immediately thereunder the names and addresses of stockholders owning or holding 1 percent or more of total amount of stock. If not owned by a corporation, the names and addresses of the individual owners must be given. If owned by a partnership or other unincorporated firm, its name and address, as well as that of each individual must be given.) Name: Non-profit corporation—No stockholders.

8. Known bondholders, mortgagees, and other security holders owning or holding 1 percent or more of total amount of bonds, mortgages or other securities (If there are none, so state): None.

9. For optional completion by publishers mailing at the regular rates (Section 132.121, Postal Service Manual). 39 U. S. C. 3626 provides in pertinent part: "No person who would have been entitled to mail matter under former section 4359 of this title shall mail such matter at the rates provided under this subsection unless he files annually with the Postal Service a written request for permission to mail matter at such rates."

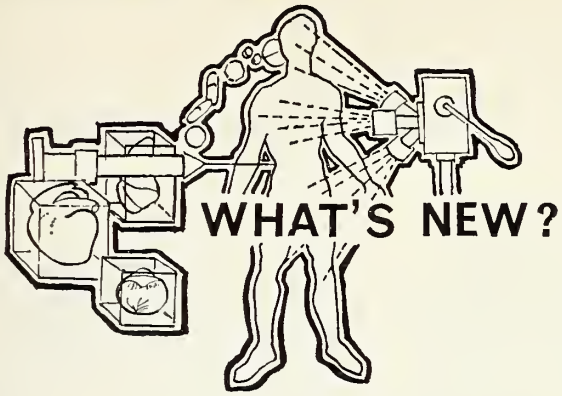
In accordance with the provisions of this statute, I hereby request permission to mail the publication named in Item 1 at the reduced postage rates presently authorized by 39 U.S.C. 3626.
(Signature and title of editor, publisher, business manager, or owner).

10. For completion by nonprofit organizations authorized to mail at special rates (Section 132.122, Postal Manual): The purpose, function, and nonprofit status of this organization and the exempt status for Federal income tax purposes: Have not changed during preceding 12 months.

11. Extent and nature of circulation.

	Average No. copies each issue during preceding 12 months	Actual No. of copies of single issue published nearest to filing date:
A. Total No. copies printed Net press run	4,853	4,860
B. Paid circulation.		
1. Sales through dealers and carriers, street vendors and counter sales	None	None
2. Mail subscription	4,590	4,618
C. Total paid circulation:	4,590	4,618
D. Free distribution by mail, carrier or other means		
1. Samples, complimentary, and other free copies	185	180
2. Copies distributed to news agents, but not sold	None	None
E. Total Distribution (Sum of C and D)	4,775	4,798
F. Office use, left-over, unaccounted, spoiled after printing:	78	62
G. Total (Sum of E & F—should equal net press run shown in A):	4,853	4,860

I certify that the statements made by me above are correct and complete. James A. Waggener.



Radiation Medical Products has a fully automated, self-contained, Lung Function Unit. Radioactive Xenon-133 is inhaled and exhaled by the patient. Progress of the gas is shown on pictures taken by a gamma camera. It is useful as an aid in diagnosis of emphysema, lung tumors, emboli, asthma and congestive heart failure.

* * *

Herculite Protective Fabrics recently tested the antibacterial activity of their Staph-Chek mattress ticking which had been in service in a New York state hospital for six years. The fabric is also flame-resistant. Both the safety features were found to be unimpaired. Herculite makes flameproof, antibacterial fabrics for mattresses, pillows, cubicle curtains, laundry cart liners and many other hospital uses.

* * *

A new Model 350 sphygmomanometer by Whittaker makes possible more accurate blood pressure determinations through the use of a sensitive microphone built into the inflation cuff. The Korotkoff sounds are picked up discriminatingly. A stethoscope is not necessary. Model 350 is battery operated and easily portable.

* * *

Pall Corporation announces improvements in its Ultipor® microfilament membrane cartridges. Its Ultipor AB non-asbestos containing, non-fiber releasing, absolute bacteria removal microfilament membrane filters are highly efficient and more economical than the more delicate polymer membrane filters.

* * *

Thermo-Mold Medical Products has a lightweight, strong, resilient, moisture-absorbent material which may be molded to various parts of the patient to form an orthopedic support. The common supports and splints such as wrist splints or back supports come in pre-cut and pre-sized forms. Sheets of the material are available for custom made devices. The material is called WARM N' FORM. A pre-shaped device may be fitted to the patient and warmed by a portable electric tray to achieve firmness in about five minutes.

* * *

Syntex announces a comprehensive asthma learning system consisting of a film, a monograph and self-evaluation test. The program can be reserved, without cost, by any group of physicians. Write Syntex, Palo Alto, Calif. 94304.

* * *

Upjohn announces Motrin® (ibuprofen), a new nonsteroidal, anti-inflammatory and analgesic agent for the long-term symptomatic treatment of osteoarthritis and rheumatoid arthritis. It is chemically unrelated to present anti-inflammatory and analgesic drugs and is the first distinctly new antiarthritic agent in nearly a decade.

* * *

Smith Kline Surgical Specialties has introduced "Proplast," an implantable material which is porous and into which body tissue will grow. It is used in such procedures as facial bone supplementation, filling mastoid cavities and in surgery that aids in support of insecure dentures.

* * *

Union Carbide is offering two new pamphlets on the freeze preservation of red cells. Basic information and clinical advantages are included in one; the other covers the use of component therapy and blood freezing. They are free of charge. Write Union Carbide, 6733 W. 65th St., Chicago 60638.

* * *

ROCOM™ PRESS has a record form for patients to carry, into which may be fitted selected complexes from an ECG tape. The form has spaces for 12 leads and a 6-second rhythm sequence. With the record forms come a guide-frame and stylus for assembling the pocket record.

* * *

Printed Motors Division has a new motorized wheelchair with gradual acceleration and exceptional maneuverability. Each wheel has its own lightweight motor which is mounted with a knurl drive; there are no drive belts or pulleys. The chair is controlled with a "joy stick" which provides direction and speed control.

* * *

Dell Books announces "Feel Free: How to Do Everything You Want Without Feeling Guilty." It's a book meant for people who have already gotten somewhere but are not sure they like being where they are. It's about changing careers or life styles. $1.50.

* * *

Orthopedic Equipment is offering an improved wrist-forearm splint which provides for positioning the thumb in the abducted position. The metal stays are radiolucent and can be adjusted. Urethane-coated nylon is used as a covering; it is soft and resilient.

* * *

Doubleday has just released "Death By Choice" by Daniel C. Maguire, Professor of Theology at Marquette. In his book Maguire examines in a clear and readable manner the major issues involved in the "right to death" controversy. 240 pages, $6.95.

* * *

News of what is new in the medicol supply industry is composed of obstracts from news releoses by manufacturers—of phormoceuticols, clinicol loborotory supplies, instruments ond surgical applionces—and book publishers. Each item is published os news ond does not necessarily constitute on endorsement of o product or recommendation for its use by THE JOURNAL or by the Indiana Stote Medical Associotion.

Annual Meeting Dates of Professional Medical and Allied Organizations

AMERICAN MEDICAL ASSOCIATION CLINICAL CONVENTION
Date Nov. 30-Dec. 4, 1974
Place Portland, Ore.

INDIANA CHAPTER, AMERICAN COLLEGE OF SURGEONS
Date Apr. 30-May 3, 1975
Place The Greenbrier, W. Va.

AMERICAN ASSOCIATION OF MEDICAL ASSISTANTS, INC., STATE OF INDIANA
Date Apr. 25-27, 1975
Place Clarksville

INDIANA PSYCHIATRIC SOCIETY
Date Second Wednesday of September, November, January, February, March and April
Place For time and place, inquire Wesley A. Kissel, M.D., 1815 N. Capitol Ave., Indianapolis 46202

NORTHERN INDIANA PSYCHIATRIC SOCIETY
Date Fourth Wednesday of every month, September through June
Place For location and program, inquire Jon Leipold, M.D., 919 E. Jefferson Blvd. South Bend 46622

INDIANA STATE MEDICAL ASSOCIATION CONVENTION
Date October 18-23, 1975
Place French Lick

INDIANA STATE NURSES ASSOCIATION
Date Oct. 16-18, 1975
Place Atkinson Hotel, Indianapolis

INDIANA DENTAL ASSOCIATION
Date May 10-13, 1975
Place Indiana Convention-Exposition Center, Indianapolis

INDIANA ORTHOPAEDIC SOCIETY
Date Mar. 21, 1975
Place Michigan City

The New Federal Supplemental Security Income Program

A new federal supplemental security income program has replaced state programs of aid to the aged, blind and disabled that was previously administered by state governments. The new federal payments are made by the Social Security Administration from general revenues to aged, blind or disabled persons who have limited income and resources.

The Indiana State Disability Determination Unit which evaluates disability claims under social security for Indiana citizens now performs the same function for the disabled and blind under the new federal program.

Some of your severely impaired patients who haven't worked long enough to be eligible for social security benefits and who have limited income and resources may be eligible under the new program. Information about the program is available at any social security office.

Physicians will be offered payment for medical evidence of record used in establishing a patient's claim for disability under this new program, which is known as the Social Security Act Title XVI.

Deaths

Paul B. Arbogast, M.D.

Dr. Paul Biehl Arbogast, 68, physician and surgeon in Vincennes for 37 years, died Aug. 18 at home.

A 1934 graduate of the Indiana University School of Medicine, Dr. Arbogast interned and served a residency at Indianapolis General Hospital. He was certified by the American Board of Abdominal Surgery in 1957.

Dr. Arbogast was the District Federal Aviation Administration medical examiner at the time of his death and during his final illness was awarded the Continuing Medical Education Award by the American Medical Association.

He served on the Commission on Constitution and Bylaws from 1968 to 1974, was a member of the American Medical Association, the Knox County Medical Society, International College of Surgeons and the Knox County Board of Health.

William E. Bayley, M.D.

Dr. William E. Bayley, Lafayette pathologist, died July 27 in Home Hospital. He was 72.

A native of Canada, Dr. Bayley was graduated from Queens University Medical College in 1926, interned at Hamilton General Hospital and completed his residency at Memphis General Hospital. Interning in pathology at the University of Wisconsin from 1930 to 1937, he was pathologist of St. Francis Hospital, La-Crosse, Wis., during 1937-43.

Dr. Bayley served with the Army Medical Corps in the Philippines during World War II, becoming chief pathologist at Home Hospital in 1946.

He was a member of the American Board of Clinical and Anatomical Pathologists and served on the Blue Shield board. He was a senior member of the Tippecanoe County Medical Society and the American Medical Association.

John W. Gustaitis, Sr., M.D.

Dr. John W. Gustaitis, Sr., Whiting, died Aug. 21 at Hines Veterans Hospital, Maywood, Ill. He was 59.

A graduate of Loyola University Medical School, Dr. Gustaitis interned at St. Catherine's Hospital, East Chicago, and was on the medical staff of that hospital from 1947 until his death.

During World War II he served with the U. S. Air Force.

Dr. Gustaitis was a member of the American College of Emergency Physicians, the Indiana Academy of Family Physicians, Lake County Medical Society and the American Medical Association.

Carl P. Huber, M.D.

Dr. Carl P. Huber, 71, retired professor and chairman of the Department of Obstetrics and Gynecology at the Indiana University School of Medicine, died July 10 at Hazelhurst, Wis.

A former president of the American Board of Obstetrics and Gynecology and the American College of Obstetricians and Gynecologists, Dr. Huber was named the I.U. School of Medicine's first Coleman Professor in 1967. He came to the medical school in 1938 as assistant professor and became head of the department in 1948.

Dr. Huber received his M.D. degree in 1928 from the University of Michigan and served his residency at Ann Arbor; he was an instructor at the university before moving to the University of Chicago, where he was attending obstetrician and gynecologist at Chicago Lying-In Hospital from 1936 to 1938.

For four years he was director of postgraduate education for the Indiana State Board of Health, and for an additional six years was consulting obstetrician and gynecologist for the board.

A member of the Marion County Medical Society and the American Medical Association, Dr. Huber became eligible this year for Senior Membership.

Robert E. Kinneman, M.D.

Dr. Robert E. Kinneman, 70, Greenfield, died in his home Aug. 14.

A graduate of the Indiana University Medical School, Dr. Kinneman began his practice at Greenfield in 1930.

During World War II, he served with the U. S. Navy, retiring from the Reserve with the rank of captain.

He was a member of the Hancock County Medical Society and the American Medical Association.

Amos C. Michael, M.D.

Dr. Amos C. Michael, M.D., Indianapolis, died August 3 in General Hospital, where he served as director of pathology from 1963 until recently. He was 73.

He previously had taught pathology at Indiana University School of Medicine, South Dakota School of Medicine and Jinnah Postgraduate Medical Center at Karachi, Pakistan.

He was graduated from the Indiana University School of Medicine in 1932.

Dr. Michael was a member of the Marion County Medical Society and the American Medical Association.

J. Frank Maurer, M.D.

Dr. J. Frank Maurer, 71, Brazil, died Sept. 13, at Clay County Hospital.

A graduate of the I.U. School of Medicine with the Class of 1927, Dr. Maurer served his internship at the University Medical Center and the Lying-In Hospital, New York City. He returned to Brazil to open his office in 1930, retiring in April 1967.

Dr. Maurer had served as president of the Clay County Medical Society from 1958 to 1966 and attained the status of Senior Member in 1974. He was also a member of the American Medical Association and the American College of Surgeons.

Arthur A. Rang, M.D.

Dr. Arthur A. Rang, 86, Washington, died June 15 at the Daviess County Hospital.

Following his graduation from the Indiana University School of Medicine in 1911, Dr. Rang interned at the old Deaconess Hospital in Indianapolis and began his practice in Washington in 1912. Dr. Rang did postgraduate work at the Mayo Clinic, the New York Postgraduate Hospital and the Cleveland Clinic and, since 1918, his practice had been limited to surgery.

Active in the Daviess County Medical Society, Dr. Rang also served as vice president of the Indiana State Medical Association, of which he was a senior member, and was a member of the American Medical Association. In 1961 he attained membership in the 50-Year Club.

Association News

EXECUTIVE COMMITTEE

August 23, 1974

The Executive Committee convened at 6:00 p.m., Friday, Aug. 23, 1974, in Banquet Room B of the Inn of the Four Winds at Lake Monroe, Dr. Donald M. Kerr, presiding.

ROLL CALL showed the following: Dr. Donald M. Kerr, Chairman-present, Drs. William R. Clark-present, Joe Dukes-present, Gilbert M. Wilhelmus-present, Vincent J. Santare-present, Hugh K. Thatcher, Jr.-present, Arvine G. Popplewell-present, Frank B. Ramsey-present, Mr. James A. Waggener-present.

THE MINUTES OF THE MEETING held June 15, 1974, were approved on motion of Dr. Thatcher seconded by Dr. Dukes.

MEMBERSHIP REPORT:

ISMA	1974	1973	INCREASE
Full dues paying	4115	4057	58
Residents	107	75	32
Exempt	521	497	24
TOTAL	4743	4629	114

AMA			
Full dues paying	3791	3741	50
Residents	105	63	42
Exempt	521	497	24
TOTAL	4417	4301	116

PAID ISMA — NOT AMA			
Full dues paying	324	316	(8) (Decrease)
Residents	2	12	10
TOTAL	326	328	2

The Membership Report as of July 31, 1974, was accepted by consent.

HEADQUARTERS OFFICE

THE SECRETARY PRESENTED A PROPOSAL FROM THE AMERICAN MEDICAL ASSOCIATION to do the membership processing work for the ISMA; and, following explanation of the program offered, upon motion of Dr. Wilhelmus seconded by Dr. Dukes, the secretary was authorized to enter into an agreement with the AMA to handle the computerization process of the Association's membership.

THE SECRETARY PRESENTED A LETTER FROM THE MERCHANTS NATIONAL BANK & Trust Company in which they propose to increase the cost of our payroll account to $60 a month; our accountant had proposed that we discontinue the use of this service and do the payroll here in our office, which would be a savings in excess of $500 a year. This was approved on motion of Dr. Wilhelmus seconded by Dr. Thatcher.

CORRESPONDENCE OF THE EXECUTIVE COMMITTEE AND THE EXECUTIVE SECRETARY was accepted as a matter of information.

THE SECRETARY PRESENTED A PROPOSED EMPLOYMENT POLICY FOR EMPLOYEES of the Association. At the suggestion of Dr. Santare, this was deferred to the next meeting.

THE SECRETARY REPORTED ON THE TEL-MED OPERATION, pointing out that the grant from the RMP would be exhausted by Sept. 1, 1974; and reading a letter from RMP suggesting that the Association seek financial assistance from other sources, as RMP would probably be out of existence in a few months. The secretary reported that he was going back to Lilly Foundation, Mead Johnson Co. and Miles Laboratories, in hopes that other sources of funds could be found.

A PROPOSED QUESTIONNAIRE TO BE USED CARRYING OUT THE CONTRACT between the State Medical Association and the State Board of Health was taken as a matter of information.

TREASURER'S REPORT

The treasurer gave a report of cash on hand, investments, and a comparison of expenditures in relation to the budget in the current fiscal year. He also informed the committee that, under the student loan program, we have nine loans outstanding, totaling $10,833.35, and it was necessary for the Association to maintain a security deposit for these loans in the amount of $870.67. Upon motion of Dr. Thatcher seconded by several the Treasurer's Report was accepted.

BUILDING COMMITTEE REPORT

DR. THATCHER, CHAIRMAN OF THE BUILDING COMMITTEE PRESENTED A letter from the architects giving the estimates of construction costs for two different sizes of addition to the existing building. By consent, it was referred to the Board of Trustees for their review and handling and presentation to the House of Delegates.

A REQUEST FOR THE USE OF THE MAILING LIST by the Indiana Support Center was deferred until after the Board Meeting, upon motion of Dr. Santare seconded by Dr. Thatcher.

A LETTER FROM THE INDIANA HOSPITAL ASSOCIATION concerning the joint meeting of the two executive committees was reviewed and, by consent, deferred until following the Board Meeting.

THE SECRETARY READ A REPORT FROM THE LEGAL COUNSEL concerning third party access to medical records, and read a letter from the Indiana Hospital Association concerning this subject and presented a folder from the Retail Credit Company from Atlanta, Ga., concerning their activity with respect to medical reports. Following discussion, this was referred, by consent, to the Board of Trustees.

A LETTER FROM INDIANA HEALTH CAREERS, INC., requesting a financial contribution was reviewed and, upon motion of Dr. Wilhelmus seconded by Dr. Dukes, the sum of $50 is to be sent to the organization.

A REQUEST OF A PHYSICIAN FOR USE OF THE MAILING LIST for announcement of the opening of an abortion clinic was turned down upon motion of Dr. Clark seconded by Dr. Dukes.

A REQUEST OF A GROUP OF PATHOLOGISTS FOR THE USE OF THE MAILING LIST was reviewed and request was denied, by consent.

THE SECRETARY ANNOUNCED THAT HE AND MR. McDERMOTT had met with the Insurance Commissioner for preliminary discussion of the malpractice situation, and the Governor had set a meeting with the Association officials and the Insurance Commissioner in his office at 10:00 a.m., October 3.

THE SECRETARY PRESENTED ON BEHALF OF DR. K. O. NEUMANN A REPORT on the malpractice survey conducted by the Commission and a request of the Commission that they be permitted to attempt to finalize an agreement between Harlan of Texas and the Association for presentation to the Board and to the House of Delegates. Permission to pursue this was given upon motion of Dr. Thatcher seconded by Dr. Dukes.

A LETTER FROM PROJECT USA announcing the number of physicians serving in Indiana under the National Service Board was read for the information of the Committee.

A LETTER FROM THE INDIANA DIABETES ASSOCIATION addressed to Dr. Dukes, president, was taken as a matter of information.

A COPY OF A LETTER FROM CONGRESSMAN HAMILTON to Dr. William Blaisdell was reviewed and taken as a matter of information.

A LETTER FROM DR. CHARLES McCALLA addressed to Dr. Santare concerning a survey made in Orange County was reviewed and, by consent, referred to the Board of Trustees.

A LETTER FROM THE AMERICAN MEDICAL ASSOCIATION CONCERNING the recommendation which has been made to them for an Indiana physician to be named to the AMA Cancer Committee was reviewed and the suggestion was approved on motion of Dr. Wilhelmus seconded by Dr. Santare.

A LETTER FROM THE UNIVERSITY OF ILLINOIS REQUESTING THE USE OF THE mailing list for a Conference on Medical Information Systems was reviewed and approved upon motion of Dr. Wilhelmus seconded by Dr. Santare.

A LETTER FROM THE INDIANA ROENTGEN SOCIETY, INC., informing the Association that they had formed a committee on peer review was reviewed and taken as a matter of information.

A LETTER FROM THE INDIANA INTERAGENCY COUNCIL ON SMOKING AND HEALTH was again reviewed and, by consent, referred to the Commission on Voluntary Health Agencies for their opinion as to whether this Association should be a member of that Council.

A REPORT FROM THE INTERN AND RESIDENTS THAT WE SPONSORED for attendance at the American Medical Association Convention in June was reviewed and taken as a matter of information.

A LETTER ADDRESSED TO DR. DUKES FROM THE THREE-I HOMEMAKERS concerning ear piercing and procedure outlined in their letter was disapproved on motion of Dr. Clark seconded by Dr. Dukes.

A LETTER FROM THE INDIANA CITIZENS' LEAGUE FOR NURSING, INC., was reviewed and, upon motion of Dr. Wilhelmus, it was taken by consent this is to be referred to the Commission on Public Health.

A LETTER FROM DR. S.O. WAIFE CONCERNING RECOMMENDATIONS FOR INDIVIDUALS TO BE NOMINATED FOR MEMBERSHIP on various committees of the U. S. Pharmacopeial Convention was reviewed and recommendations were accepted upon motion of Dr. Thatcher and approved by consent.

A LETTER FROM THE INDIANA STATE NURSES' ASSOCIATION concerning a joint statement on coronary and intensive care units was reviewed; it was the opinion of the Executive Committee and approved by consent that these statements are the responsibility of the hospital medical staff and that not all hospitals in the state would find standardized policies for all situtations tenable.

THE MINUTES OF THE COMMISSION ON PUBLIC HEALTH commenting on the health conditions in jails and prisons and other correctional facilities was reviewed for the information of the committee.

A LETTER FROM "PEOPLE TO PEOPLE INTERNATIONAL" seeking a sponsor for one of their travel programs was reviewed and taken as a matter of information.

A LETTER FROM MRS. HERBERT L. EGBERT seeking the approval of the Association to pick up the mailing cost for the publication of the WASAMA (Auxiliary of the Student American Medical Association) was reviewed and upon motion of Dr. Thatcher and taken by consent, the Secretary is to inform Mrs. Egbert that they would like to support this publication, but funds are not available at this time to assist them.

A LETTER FROM THE INDIANA PUBLIC HEALTH ASSOCIATION outlining the proposed program for informing the legislators of various health proposals was reviewed and taken as a matter of information.

A LETTER FROM BLUE SHIELD ANNOUNCING the updating of physician profiles under Medicare and Medicaid was reviewed for the information of the committee.

A LETTER FROM AN INDIANA PHYSICIAN CONCERNING PROBLEMS HE WAS HAVING with Blue Shield was referred to Dr. Gattman upon motion of Dr. Wilhelmus and taken by consent.

A LETTER FROM TWO PHYSICIANS CONCERNING PROBLEMS THEY WERE HAVING with Blue Shield was reviewed and Dr. Dukes announced the matter had been resolved.

CONVENTION MATTERS

THE SECRETARY AGAIN REQUESTED AN OPINION AS TO WHETHER THERE would be a response from the Fifty-Year Club, and, if so, by whom; this was again left to President Dukes.

THE MATTER OF THE FIFTY-YEAR CLUB MEMBERS BEING GUESTS OF THE ASSOCIATION at the President's reception and dinner was discussed and, upon motion of Dr. Thatcher seconded by Dr. Dukes, the Fifty-Year Club members will be charged for attendance the same as any other members of the Association.

A REQUEST OF THE CHAIRMEN OF THE GOLF AND TENNIS COMMITTEES for prize money for the tournament was reviewed, and, upon motion of Dr. Santare and taken by consent, the motion was to include the prize money in registration fees for these tournaments.

THE MINUTES OF THE MEETING OF THE COMMISSION ON MEDICAL EDUCATION AND LICENSURE SEEKING $500 for a display at the Annual Meeting. By consent, the Commission is to be advised that the Association will provide the space only.

INDEPENDENT CORPORATION FOR PEER REVIEW. The proposed articles of incorporation of I-Medic, Inc., was taken as a matter of information, inasmuch as this will be explained to the Board of Trustees at their meeting on Saturday.

THE JOURNAL

THE EDITOR REPORTED ON THE OUTLOOK FOR THE JOURNAL FOR THE COMING YEAR. The report was taken as a matter of information.

A REQUEST FOR ADVERTISING SPACE BY AN ORGANIZATION IN INDIANAPOLIS. The Secretary was instructed to check with the Better Business Bureau; if they approve of this firm, The Journal could accept this advertising.

A REPORT FROM THE STATE JOURNAL ADVERTISING BUREAU CONCERNING PUBLICATION costs of journals was reviewed and taken as a matter of information.

A NOTIFICATION FROM THE PRINTER OF THE JOURNAL ANNOUNCING THE SECOND PAPER PRICE INCREASE for the year 1974 was reviewed and taken as a matter of information.

A LETTER FROM THE STATE JOURNAL ADVERTISING BUREAU SUGGESTING THAT WE MIGHT like to take a page in the Health Media Guide at a cost of $8.40 was approved upon motion of Dr. Santare and seconded by Dr. Dukes.

AN APPLICATION OF AN INDIANA PHYSICIAN FOR MEDICAL DEFENSE was approved by consent.

NEW BUSINESS

A REQUEST OF A COUNTY SOCIETY FOR THE ASSOCIATION to distribute a letter and a resolution to all the county societies in the state was re-

viewed and this matter was deferred to the meeting following the Board Meeting, when it will again be discussed.

FUTURE MEETINGS

THE 34TH ANNUAL CONGRESS ON OCCUPATIONAL HEALTH, SEPT. 9 and 10—upon motion of Dr. Dukes and taken by consent, no representative will be sent.

AMA CONFERENCE ON HEALTH MANPOWER—OCT. 31-NOV. 2, Chicago. It was thought that Dr. Corcoran would be at this meeting and, therefore, no other representative would be sent.

THE FOURTH BIENNIAL CONFERENCE ON CONTINUING MEDICAL EDUCATION—October 2-3 in Chicago. Upon motion of Dr. Dukes and taken by consent, Mr. Raffensperger is to attend this meeting.

There being no further business, the committee recessed to meet again following the conclusion of the meeting of the Board of Trustees.

EXECUTIVE COMMITTEE

Sunday, August 25, 1974

Dr. Donald M. Kerr, chairman, presided.

The Executive Committee convened at the conclusion of the meeting of the Board of Trustees at the Inn of the Four Winds.

Roll call showed the following present: Drs. Kerr, Clark, Dukes, Wilhelmus, Santare, and Thatcher and Mr. Waggener.

THE COMMITTEE AGAIN DISCUSSED THE CLARK COUNTY REQUEST and, upon motion of Dr. Dukes and seconded by Dr. Wilhelmus, it was approved that the Association would prepare the information, but the Clark County Society would have to stand full expense for the preparation and mailing of this letter.

A REQUEST OF THE INDIANA SUPPORT CENTER FOR USE OF THE ASSOCIATION'S mailing list was approved upon motion of Dr. Dukes seconded by Dr. Santare.

There being no further business, the Committee adjourned to meet again at 3:00 p.m. on Thursday, Oct. 3 at the Columbia Club in Indianapolis.

How to Win at Wordmanship

TIRED OF HACKING through the etymological thickets of governmentese and corporate jargon? From the following lexicon of 30 carefully chosen words, you can convert that frustration into fulfillment.

0. integrated	0. management	0. options
1. total	1. organizational	1. flexibility
2. systematized	2. monitored	2. capability
3. parallel	3. reciprocal	3. mobility
4. functional	4. digital	4. programming
5. responsive	5. logistical	5. concept
6. optional	6. transitional	6. time phase
7. synchronized	7. incremental	7. projection
8. compatible	8. third generation	8. hardware
9. balanced	9. policy	9. contingency

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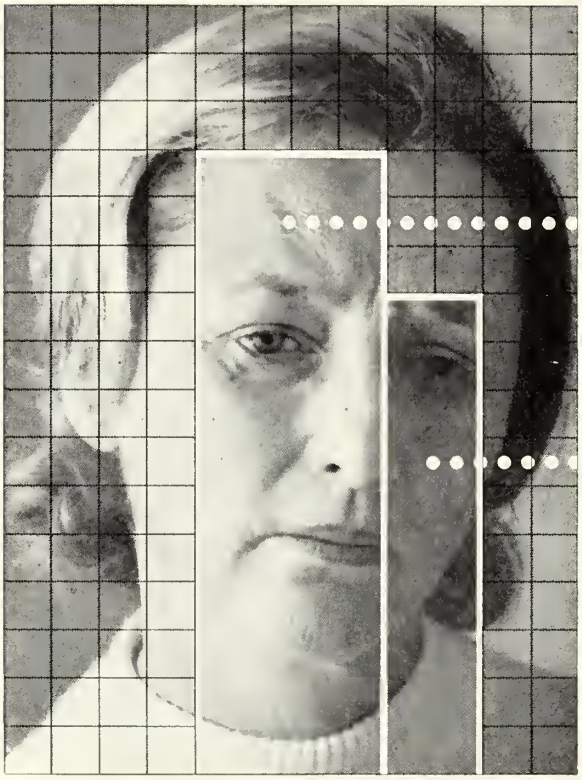
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- Associated depressive symptoms

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For further information on this subject, the following references are provided:

1. Henry BW, *et al: Dis Nerv Syst 30*:675-679, Oct 1969.
2. Hollister LE, *et al: Arch Gen Psychiatry 24*:273-278, Mar 1971.
3. Claghorn J: *Psychosomatics 11*:438-441, Sept-Oct 1970.



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in psychoneurotic anxiety states with associated depressive symptoms

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Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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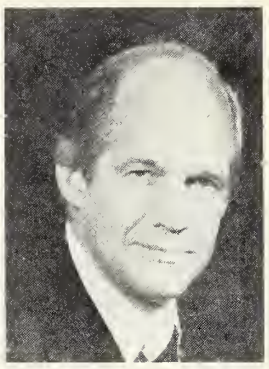
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President's Page



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Christmas is holly and tinselled trees, a heart that's filled with memories.

Christmas is a hearth fire that dances and gleams, a child's face, expectant, bright with dreams.

Christmas is a gift from heaven above.

Christmas is peace . . . Christmas is love.

May the Peace and Joy of Christmas remain in your hearts and home throughout the coming year.

Gilbert M. Wilhelmus, M. D.
President
Indiana State Medical Association



The Journal
of the INDIANA STATE MEDICAL ASSOCIATION

Office of Publication
3935 N. Meridian, Indianapolis, Indiana 46208

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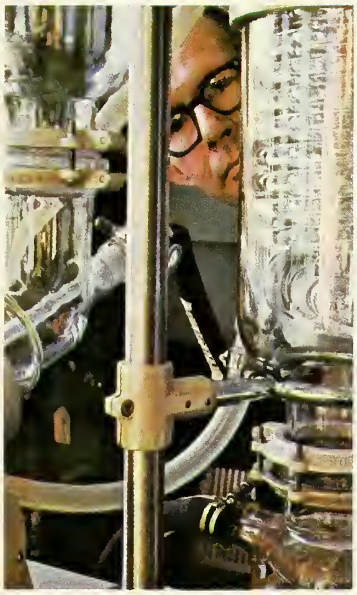
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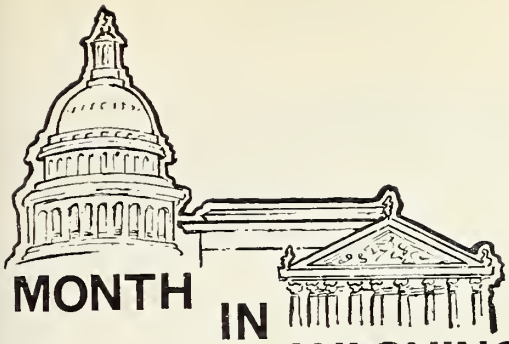
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MONTH IN WASHINGTON

This summary of what is happening in Washington is prepared by AMA's Capitol office and air-mailed to The Journal on the first of each month preceding month of issue.

Though Senator Russell Long (D-La.) may make an attempt to win Senate approval of his social security-catastrophic national health insurance proposal when the Congress returns in late November, most Capitol Hill observers believe such legislation's chances of passage are less than that of Henry Mencken's snowball in hell.

Updating Position on NHI

The American Medical Association is now in the process of reviewing and updating its position on national health insurance, Malcolm C. Todd, M.D., has told Washington groups.

"Our objective is to make the AMA's national health insurance proposal more flexible, while at the same time maintaining certain basic precepts," Dr. Todd said.

"If necessary, we may compromise on the method of financing we adopt. But we are not willing to fund national health insurance through an increase in Social Security taxes; nor are we willing to see the program administered by the Social Security Administration.

"We want a financing mechanism for comprehensive health insurance that will do the most at the least cost. This could involve:

- Increase employer-employee contributions for private health insurance;
- The use of general tax revenues;
- Or, an individual tax credit to be applied toward full health care protection. This latter method was, of course, the method employed in Medicredit.

"The important point is that we cannot countenance greater fiscal and bureaucratic authority for the Social Security Administration or an increase in the Social Security tax.

"Any payroll tax, whether collected under Social Security or not, constitutes the most insidious form of taxation that can be invoked by government. It is a totally regressive tax that weighs heavily on low and middle income workers and lightly on the affluent.

"Finally, the measure that emerges will provide comprehensive health care benefits as well as protection against the catastrophic costs of prolonged illness for every American," Dr. Todd said.

Bills Await Action by Congress

A batch of major health bills is hanging fire for the "lame duck" session of Congress starting Nov. 18. Comprehensive health planning bills have cleared Senate but not the House. Though no public utility-type regulation is in prospect, other measures strengthening government planning authority abound.

Health manpower legislation with provisions for federal service in shortage areas is through Senate. House action is expected shortly after Congress returns. There is a possibility that one or both may be stalled in conference as the Administration now wishes simple extension of present programs.

A health revenue sharing bill will be taken up again by a House-Senate conference. This measure extends state health block grants, community mental health centers, family planning, migrant health and neighborhood health center programs. It should secure congressional enactment this year.

The Health, Education, and Welfare appropriations bill still has to be completed.

No chance is seen for passage of the Omnibus Drug amendments bill that would provide Medicare outpatient drug benefits, a Federal Formulary, and the Administration's low-cost drug plan for Medicare-Medicaid patients.

HMO Regulations Issued; More to Come

The Health, Education, and Welfare Department has issued final regulations on benefits and structure of Health Maintenance Organizations, giving the green light to federal grants launching the program.

The regulations set forth the rules and restrictions and benefits that must be followed in order for organizations to qualify as HMOs and receive federal aid. The $325 million HMO program was approved by Congress in 1973.

Continued

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8.	Eugene M. Gillum, Portland	James S. Fitzpatrick, Partland	June 4, 1975, Portland
9.	Milton W. Erdel, Frankfort	Harry T. Stout, Frankfort	Rensselaer
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Continued

Grants can now be made among the 125 groups that have applied for funds to conduct feasibility studies, planning and development.

The HMO Act authorizes federal support for five years "to demonstrate more broadly the concept of organizations delivering comprehensive health care services on a prepaid basis." Last year Congress appropriated $61 million. The Administration sought $60 million this year, but the Senate approved only $18 million because of a delay due to the development of the complicated regulations.

The regulations specify basic services to be provided in return for fixed payments made on a periodic basis without regard to the frequency, extent or kind of services provided, with the payments set on a community rating system. These may be supplemented by what the regulations call "nominal copayments" limited under a variety of formulas.

Before the HMO program can be launched still more regulations will have to be completed. The most important is the statutory requirement that employers with more than 25 workers offer the employees the option of joining a qualified HMO if one is available. These proposed regulations are slated to be issued soon, but final ones are some months off.

Though suggestions were made to exempt HMOs from Professional Standards Review Organization (PSRO) authority, HEW rejected them, declaring that there is a need "to assure that suitable procedures are applied to HMO services to assure they conform to appropriate professional standards for the provision of health care applicable to other providers."

Basic HMO benefits must include:

- physicians services (including consultant and referral services by a physician);
- outpatient services and inpatient hospital services;
- medically necessary outpatient and inpatient emergency health services;
- short-term (not to exceed twenty visits), outpatient evaluation and crisis intervention mental health services;
- medical treatment and referral services (including referral services to appropriate ancillary services) for the abuse of or addiction to alcohol and drugs;
- diagnostic laboratory and diagnostic and therapeutic radiologic services;
- home health services; and
- preventive health services (including voluntary family planning services, services for infertility, preventive dental care for children, and children's eye examinations conducted to determine the need for vision correction).

All Not Well with Prepaid Plans in California

The General Accounting Office has charged that per capita payments for Medicaid patients enrolled in prepaid health plans in California exceeded average fee-for-service costs on one of two pilot projects studied.

In a report to the Senate Finance Committee, the GAO also said that Medicaid enrollees in the prepaid plans "have made many complaints about the quality of medical care," especially the lack of a personal family physician.

About three percent of the Medicaid patients in fiscal 1972 dropped out of the plans each month with the exception of the Sacramento Foundation Community Health plan where the rate was only .3 percent, a difference attributed by GAO probably to the fact that the Foundation allows most enrollees to remain with their family physicians.

However, GAO, Congress' watchdog on federal expenditures, said the Foundation was paid $406,000 more for Medicaid patients than per-capita fee-for-service estimates for the group.

The agency recommended that the HEW Department establish surveillance mechanisms to insure that costs of HMO do not exceed the costs of fee-for-service.

GAO Withdraws Report

A controversial draft report that showed two Blue Cross Medicare intermediaries with substantially lower administrative costs than those of the Social Security Administration's Bureau of Health Insurance has been pulled back by the General Accounting Office and is being redone, according to the *Washington Report on Medicine and Health*. BHI has objected to the comparison as invalid and GAO has protested Blue Cross use of the draft which had been put out on a confidential basis.

Physician Assistants Received Favorably

Physicians, patients and fellow workers have reacted favorably to the Physician Assistants (PA) employed in a pilot experiment by Kaiser Foundation Health Plan, according to a report on the program.

At present seven PAs are on duty at Kaiser. The first was hired in 1970, a graduate of the Duke University PA program and a former military corpsman.

There was concern by some physicians and administrators, but "the greatest resistance came from the nursing department," writes Kaiser official Paul Lairson, M.D., in *Inquiry*, the Blue Cross Association magazine.

As the nurses began to work with the PA and learned from experience that there was more of an "equal relationship" with him than with the physicians, they became a "traditional team," Dr. Lairson declared.

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Furthermore, "all but one of the physicians who worked in the clinic with the PA came to favor expanding the program," he said.

The PA saw approximately 20 patients per day at the Vancouver, Wash., clinic. He was given three physical examination appointments and the rest of his time was rapidly filled with the "treatment of relatively minor medical and surgical problems, whether by appointment or on a 'drop-in' basis." More severe or chronic problems were transferred to the internist or other specialist.

Foreign Conventions Discouraged

The tax reform bill before the House Ways and Means Committee has a provision to discourage professional conventions by American organizations in foreign countries.

Exempted would be Canada, Mexico, Bermuda and the Caribbean. The taxpayer must show that it was "more reasonable for the meeting to be held outside North America," to secure a business expense deduction. Not affected would be meetings announced before September 11, 1974.

The amendment is aimed at national conventions being held in faraway tourist attractions where attendees deduct their travel and other expenses as business-connected.

Medicare Costs to Change

The Department of Health, Education, and Welfare has announced that commencing with the first of the new year the Medicare hospital deductible will jump to $92. The present deductible is $84.

HEW said that the $92 deductible is equivalent to the average cost of one day of hospitalization. The increased payment was brought about by rising hospital costs, HEW said.

The Medicare law requires an annual review of hospital costs under Medicare and an adjustment of the portion of the bill for which a Medicare beneficiary is responsible, if the costs have risen substantially.

When the hospital deductible amount changes, the law requires comparable changes in the dollar amounts that a Medicare beneficiary pays toward a hospital stay of more than 60 days, or an Extended Care Facility (ECF) stay of more than 20 days.

When a Medicare beneficiary has a hospital stay of more than 60 days, he will pay $23 a day for the 61st through the 90th day, up from the present $21 per day. If he has a posthospital stay of over 20 days in an ECF, he will pay $11.50 per day toward the cost of the 21st day through the 100th day, up from the present $10.50 per day.

If a beneficiary uses his "lifetime reserve" days, the extra 60 hospital days a beneficiary can use when he needs more than 90 days of hospital care in the same benefit period will cost him $46 for each reserve day used, instead of the present $42 per day. ◄



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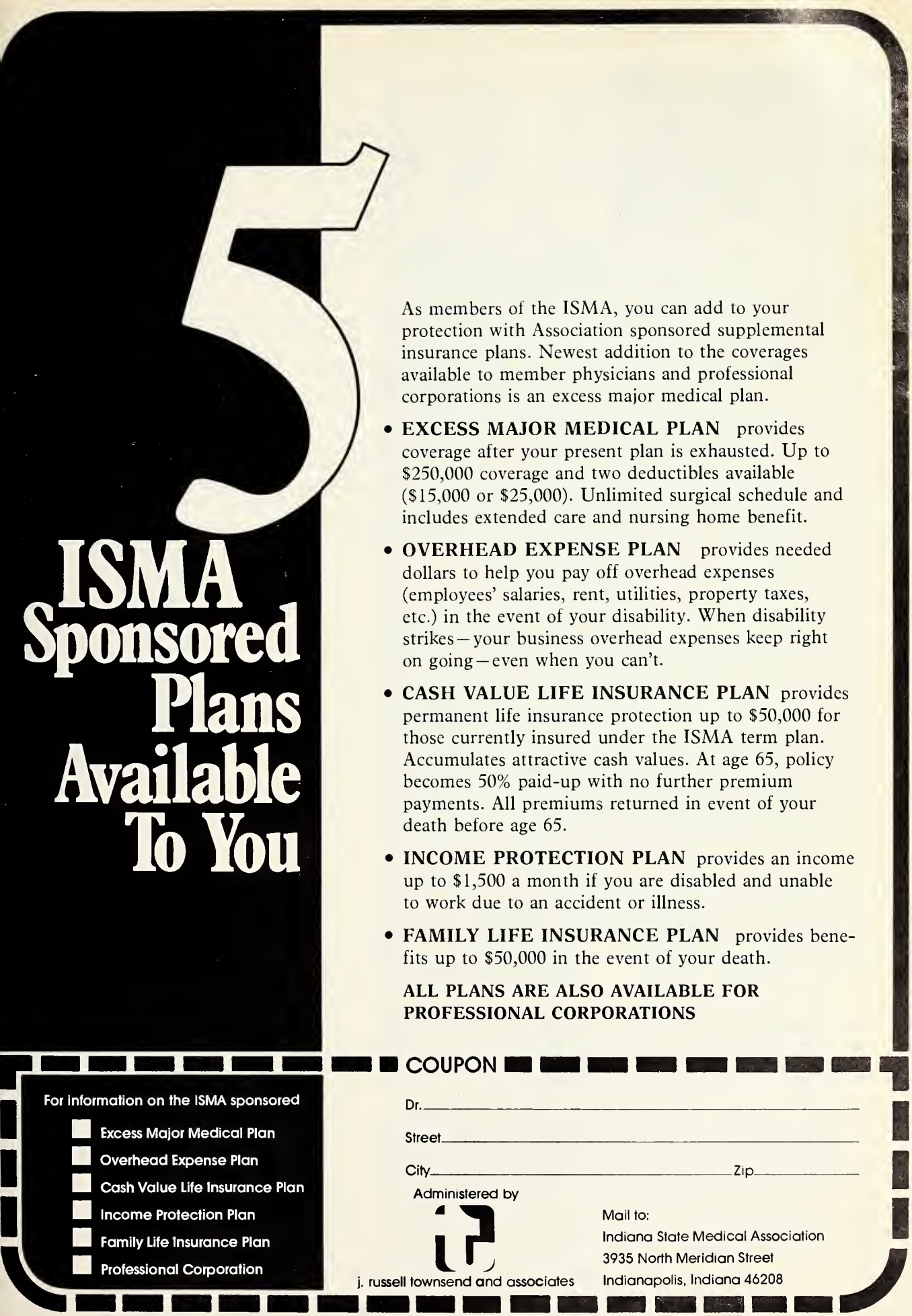
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Agatha, a registered nurse, believed in taking lots of initiative in her work. Among other things she meddled in the private affairs of patients, overruled medical instructions from doctors, and denounced doctors and patients to each other with fine abandon.

Finally, on the basis of repeated complaints, a state board revoked Agatha's license. She carried a protest into court, but the board's action was upheld.

Nursing, like the other healing arts, is usually subject to supervision by a state board set up to safeguard the public. Although regulations vary, they generally impose a high standard of conduct in keeping with a nurse's responsibilities.

But the courts also recognize that revocation of a nurse's license is a drastic punishment, not to be imposed lightly.

Thus:

The night nurse in an obstetrics case, asked by the patient to call a doctor, decided it wasn't necessary. Was this adequate grounds, as alleged afterward, for revoking her license?

A court said no, pointing out that the patient 1) had gotten good care from the nurse, and 2) had not really needed the doctor after all. The complaint was too minor, said the court, to justify such a penalty on the nurse.

Of course nurses, like doctors, may be held liable for malpractice —such as carelessly giving a patient the wrong medicine.

But there is no malpractice if there is no negligence. In another case, a woman patient who had fallen out of her hospital bed sued the nurse for failing to put up bed rails. However, there had been no instructions from the doctor about bed rails, nor any advance indications that they were needed.

Finding no malpractice, the court said a nurse could not be held liable merely because something happened to go wrong.

A public service feature of the American Bar Association and the Indiana State Bar Association. Written by Will Bernard.

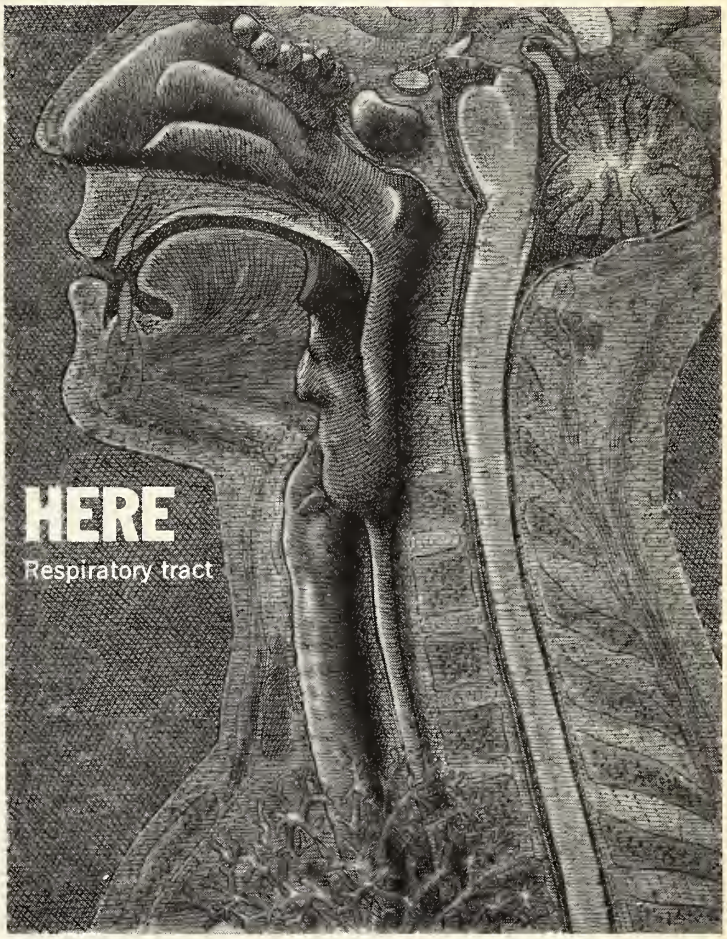
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INDIANA STATE BOARD OF HEALTH

MONTHLY REPORT—October 1974

Disease	Oct. 1974	Sept. 1974	Aug. 1974	Oct. 1973	Oct. 1972
Animal Bites	981	894	1251	812	712
Chickenpox	139	53	69	68	100
Conjunctivitis	186	140	173	199	162
Diphtheria	0	0	0	0	0
Dysentery, Unspecified	75	101	117	45	23
Gonorrhea	986	1163	1838	996	671
Impetigo	265	252	182	324	199
Infectious Hepatitis	47	44	73	68	37
Infectious Mononucleosis	78	68	52	93	100
Influenza	3488	2546	2933	2511	2584
Measles					
Rubeola	15	17	14	17	32
Rubella	31	41	49	11	22
Meningococcic Meningitis	2	2	3	1	1
Meningitis, Other	3	8	7	2	3
Mumps	36	21	34	167	27
Pertussis (Whooping Cough)	6	3	10	2	0
Pneumonia	434	290	515	443	361
Poliomyelitis	0	0	0	0	0
Streptococcal Infections	1054	1007	1175	1016	1056
Syphilis					
Primary and Secondary	13	10	29	37	26
All Other Syphilis	75	109	122	88	73
Tinea Capitis	20	11	7	21	12
Tuberculosis (Active)	46	31	74	23	66

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The Role of the Detail Man

Opinion & Dialogue

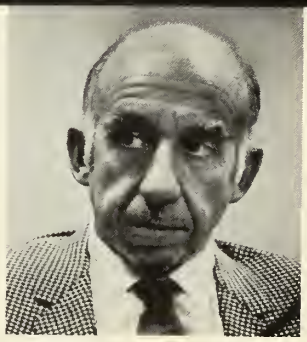


Dr. Willard Gobbell
Family Physician
Encino, California

"I may be prejudiced, but I a very much in favor of the detail m I meet. Most of them are knowled able about the drugs they promot and can be a great help in acquai ing me with new medication."

Family Physician's Perception

I think that most general practitioners in this area feel as I do about the detail man. Over the years I have gotten to know most the men who visit me regularly ar they in turn have become aware c my particular interests and the na ture of my practice. They, there- fore, limit their discussion as muc as possible to the areas of interes to me. Since I usually see the sam representative again in future visits, it is in his best interest to supply me with the most honest, factual, as well as up-to-date inforrnation about his products.



Dr. Jeremiah Stamler
Chairman
Department of Community Health and Preventive Medicine, and Dingman Professor of Cardiology
Northwestern University Medical School

"In the total picture of dealir with health problems in this coun there is a potential for detail men to play a meaningful role."

The Positive Influence

My contact with representa- tives and salesmen of the pharma ceutical industry is the type of cor tact that people in a medical cente research people, and academic people have and that's in all likelih on a somewhat different level from that of the practicing physician.

Let me touch on how I persor ally perceive the role of the sales representative. These men reach large numbers of health profes- sionals. Thus they could be—and at times actually are—disseminа- tors of useful information. They could consistently serve a real edu cational function in their ability to discuss their products.

At present they do distribute printed material, brochures and pamphlets—some of it scientific- ally sound and therefore truly use- ful—as well as some excellent film produced by the pharmaceutical industry. When they function in thi

He a Source of Information?

Yes, with certain reservations. he average sales representative as a great fund of information oout the drug products he is re- ponsible for. He is usually able to nswer most questions fully and telligently. He can also supply eprints of articles that contain a reat deal of information. Here, oo, I exercise some caution. I usu- ly accept most of the statements nd opinions that I find in the apers and studies which come om the larger teaching facilities. goes without saying that a physi- an should also rely on other ources for his information on harmacology.

raining of Sales Representatives

Ideally, a candidate for the osition as a sales representative f a pharmaceutical company hould be a graduate pharmacist ho has a questioning mind. I don't hink this is possible in every case, nd so it becomes the responsibility of the pharmaceutical company to train these individuals comprehensively. It is of very great importance that the detail man's knowledge of the product he represents be constantly reviewed as well as updated. This phase of the sales representative's education should be a major responsibility of the medical department of the pharmaceutical company.

I am certain that most of these companies take special care to give their detail men a great deal of information about the products they produce—information about indications, contraindications, side effects and precautions. Yet, although most of the detail men are well informed, some, unfortunately, are not. It might be helpful if sales representatives were reassessed every few years to determine whether or not they are able to fulfill their important function. Incidentally, I feel the same way about periodic assessments of everyone in the health care field, whether they be general practitioners, surgeons or salesmen.

Value of Sampling

I personally am in favor of limited sampling. I do not use sampling in order to perform clinical testing of a drug. I feel that drug testing should rightly be left to the pharmacology researcher and to the large teaching institutions where such testing can be done in a controlled environment.

I do not use samples as a "starter dose" for my patients. I do, however, find samples of drugs to be of value in that they permit me to see what the particular medication looks like. I get to see the various forms of the particular medication at first hand, and if it is in a liquid form I take the time to taste it. In that way I am able to give my patients more complete information about the particular medications that I prescribe for them.

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apacity they are indeed useful; articularly in the fact that they isseminate broadly based educa- onal material and serve not just s "pushers" of their drugs.

he Other Side of the Coin

Obviously, the pharmaceuti- al companies are not producing all his material as a labor of love— hey are in the business of selling roducts for profit. In this regard he ambitious and improperly moti- ated sales representative can xert a negative influence on the racticing physician, both by pre- enting a one-sided picture of his roduct, and by encouraging the ractitioner to depend too heavily n drugs for his total therapy. In hese ways, the salesman has often istorted objective reality and ndermined his potential role as an ducator.

he Industry Responsibility

Since the detail man must be n information resource as well as representative of his particular harmaceutical company, he hould be carefully selected and thoroughly trained. That training, perforce, must be an ongoing one. There must be a continuing battle within and with the pharmaceutical industry for high quality not only in the selection and training of its sales representatives, but also in the development of all of its promotional and educational material.

The industry must be ready to accept constructive as well as corrective criticism from experts in the field and consumer spokesmen, and be willing to accept independent peer review. The better educated and prepared the salesman is, the more medically accurate his materials, the better off the pharmaceutical industry, health professionals and the public—*i.e.,* the patients—will be.

Physician Responsibility

The practicing physician is in constant need of up-dated information on therapeutics, including drugs. He should and does make use of drug information and answers to specific questions supplied by the pharmaceutical representative. However, that information must not be his main source of continuing education. The practitioner must keep up with what is current by making use of scientific journals, refresher courses, and information received at scientific meetings.

The practicing physician not only has the right, but has the responsibility to demand that the pharmaceutical company and its representatives supply a high level of valid and useful information. I feel certain that if such a high level is demanded by the physician as well as the public, this demand will be met by an alert and concerned pharmaceutical industry.

From my experience, my impression is that sectors of the pharmaceutical industry are indeed ethical. I challenge the industry as a whole to live up to that word in its finest sense.

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The Journal of the INDIANA STATE MEDICAL ASSOCIATION

Volume 67—December 1974—Number 12

The sodium-restricted diet is useful therapeutically but must be prescribed, constructed and managed with great care and wisdom.

The Sodium-Restricted Diet Revisited

W. D. SNIVELY, JR., M.D.
KAY T. ROBERTS, R.N., M.A.
DONNA R. BESHEAR
Evansville

SINCE sodium restriction was first introduced into the medical armamentarium, its popularity has waxed and waned with the ever-changing therapeutic styles. With the useful cluster of potent diuretics ushered in during the fifties, the sodium-restricted diet appears to have been held in increasing disdain by many, if not most, physicians. We believe it does not deserve this fate, for sodium restriction has a legitimate place in modern therapy. Yet, if not employed properly, it is something worse than useless. This paper reports on a study of the current status and usefulness of sodium-restricted diets, with particular emphasis on their thoughtful use.

In many respects, sodium and potassium vie as antagonists in human physiologic processes. Hence, any review of the goals and effects of sodium restriction must consider potassium. Sodium is the chief cation of the extracellular fluid, potassium of the cellular fluid. And yet, potassium is the second most important cation of the extracellular fluid, sodium the second most important of the cellular fluid. Geologists have a logical explanation for these otherwise inexplicable facts. They point out that the pre-Cambrian seas of two billion years ago, about the time when cellular life first appeared on the planet, were rich in potassium, with lesser amounts of sodium, while the Cambrian seas of some 250 million years ago, when vertebrate life first came ashore, were rich in sodium, with much lesser amounts of potassium. These facts might explain why the cells, with their pre-Cambrian origin, have potassium as the predominant cation, and the extracellular fluid, with its origin in the more salty Cambrian seas, has sodium as its cardinal cation.

Consideration of sodium and potassium reveals other striking contrasts. A vegetarian, or herbivore, diet contains enormous amounts of potassium and quite little sodium. A meat, or carnivore, diet, on the other hand, is rich in sodium, with relatively slight amounts of potassium. Man, in his remote ancestry, was apparently an herbivore. And now, with few exceptions, he is an omnivore, having added meat and meat products to his diet. Yet, in many respects, his kidneys behave as if he were still eating the vegetable and fruit diet of some prehistoric Eden. For the kidneys save sodium parsimoniously and are profligate in their wastage of potassium. Indeed, while sodium conservation is superb, potassium conservation—at times, at least—appears to be almost nonexistent.

The earliest records of man show

This study was made possible by a generous grant from the University of Evansville Alumni Association, which provided funds from the Alumni Research and Scholarly Activity Fellowships.

Doctor Snively is professor of life sciences, University of Evansville School of Nursing, and clinical professor of pediatrics, Indiana University School of Medicine. Nurse Roberts is assistant professor of nursing, University of Evansville. Mrs. Beshear is a research associate.

The authors take pleasure in expressing their appreciation to the following individuals who played an important role in carrying out the study: Rebecca Willhouse, Kathy Doem, Michelene Cho and Madeline Burns.

salt to have been widely used. The popularity of the element as a condiment apparently began with primitive man. As the centuries went by, the preservative qualities of salt were recognized and utilized, and many nationalities of man became accustomed to eating highly salted foods. From earliest times, the salt trade figured prominently in military, social and political history.[20] Wars were waged for sources of salt. During the England of the 16th to 19th centuries, salt was heavily taxed. The Earl of Dundonald wrote in 1785: "Every year in England, ten thousand people are seized for salt smuggling and three hundred men are sent to the gallows for contraband trade in salt and tobacco."[11] Scarcity of salt in Africa contributed to the 19th century slave trade, with wives and children sold into slavery in exchange for salt.

The ancient Jews held salt in such high esteem that a man could divorce his wife if she did not salt his food properly.[23] The term "the salt of the earth" is still considered a compliment of the highest order. Roman soldiers were paid in salt—hence the term salary. An especially good soldier was spoken of as being "worth his salt." In medieval England, to be placed "above the salt" at the dining table was truly an honor, a mark of favor and rank.[6] Servants and members of the lower castes always dined "below the salt."

The use of salt varies widely in different parts of the world. South American Indians may eat as little as 75 mg daily, while in some areas of Japan the average daily intake is in excess of 20,000 mg. Most Americans ingest at least 3,000 to 5,000 mg of salt a day. But the craving for salt is not based on a physiologic need for it. The desire is often stimulated early in infancy, usually by well-meaning adults who add salt to the baby's food in order to suit their own tastes. But once the appetite for salt is stimulated, it develops independently of need. The amount ingested by a given individual is largely governed by culture, custom and food habits ingrained early in life.[11]

The Parisian Jean de Marcounille recognized the importance of salt when he stated in 1584: "The sacredness and dignity of salt! This mineral is like unto the four elements—earth, air, fire and water, so universal, so necessary to life, it is the fifth element."[6]

Despite the universally recognized physiologic importance of salt, many persons have doubted the need for it in the quantities that habit often dictates. In *Gulliver's Travels,* Jonathan Swift wrote of Gulliver's visit with the Houyhnhnms, the horses that used humans for servants. Since the horses naturally ate a diet extremely low in salt, Gulliver was forced to eat the same diet. He concluded, with amazing insight: "I was at first at a great loss for salt; but custom soon reconciled the want of it; and I am confident, that the frequent use of salt among us, is an effect of luxury, and was first introduced only as a provocative to drink; except where it is necessary for preserving of flesh in long voyages, or in places remote from great markets. For we observe no animal to be fond of it but man; and as to my self, when I left this country, it was a great while before I could endure the taste of it in any thing that I ate."[1]

Many years later the explorer Stefanson reported, "It was here [among the Eskimoes] that I learned from experience what I already knew theoretically, that [added] salt is not necessary for health and that the desire for it disappears in about three months when one is without it."[5]

And still more recently, Dahl stated, ". . . whereas metabolic balance can be maintained on sodium intakes of only a few hundred milligrams, or less, the average intake in contemporary American society commonly exceeds this by a factor of 20."[18]

The body possesses a highly efficient mechanism for regulating the extracellular fluid concentration of sodium. During periods of decreased intake or increased loss, the mechanism acts to conserve sodium. Important in this conservation is the hormone aldosterone secreted by the zona glomerulosa of the adrenal cortex. Aldosterone promotes sodium retention and potassium loss via a complex feedback mechanism involving the afferent arterioles, the juxtaglomerular apparatus, and the macula densa of the distal tubule. When fluid volume deficit occurs, a resultant decrease in glomerular filtration aids in sodium conservation simply because there is less sodium in the tubular urine to be exchanged for potassium and hydrogen in the peritubular capillaries of the distal tubules. Because of this efficient sodium conservation, patients being maintained on a sodium-restricted diet are seldom in danger of developing sodium deficit —at least, as long as there is relatively normal renal function.

When sodium intake increases, the regulating mechanism acts to rid the body of excesses. Promptly, the sodium excretion and glomerular filtration rate increase. The increase in sodium excretion is apparently related to decreased reabsorption of sodium from the proximal tubules of the kidneys.

In the process of acclimatization, increased quantities of aldosterone are produced. These cause retention of sodium and excretion of potassium. Indeed, an individual on a well-balanced diet can develop potassium deficit over months of working in an extremely hot climate because of this increased production of aldosterone due to acclimatization. One would think that persons suffering from primary hyperaldosteronism due to an adrenocortical adenoma would develop pronounced edema. They do not —probably because tubular excretion of sodium is controlled by a third factor, perhaps a hormone, whose chemical structure and site of origin are unknown.[34]

An acute increase in the sodium level of extracellular fluid produces severe reactions. Indeed, acute sodium excess is one of the most dangerous of all body fluid disturb-

ances. A common form of execution in ancient times was to force the condemned individual to eat a cup of salt. Sodium excess can result from decreased intake or increased output of water, or from increased intake or decreased output of sodium—although interestingly enough, the more important of these influences relate to water intake.

Acute sodium excess can follow excessive administration of concentrated oral electrolytes mixtures. It may occur in any condition in which more water is lost than electrolytes; an example is tracheobronchitis, with its high fever and deep, rapid respiration. Unconscious patients can develop sodium excess simply because they cannot drink water. Infants are especially prone to develop acute sodium excess; the mortality rate is 50% in the best hospitals.

Clinical findings of sodium excess include dry, sticky mucous membranes, flushed skin, intense thirst, and rough, dry tongue. Body tissues are firm. Oliguria or anuria appears, and the patient may have fever. He appears agitated and restless, may develop mania or convulsions. His reflexes are decreased.

Chronic ingestion of large amounts of sodium, as in a high-salt diet, can apparently lead to hypertension, especially in genetically predisposed individuals. It is a factor in the pathophysiology of other ailments as well. Rettenbacher and Schmidt first inquired into the effects of salt in disease states about 1850. During the ensuing years, the merit of salt withdrawal in certain diseases has been repeatedly demonstrated.[11] Allen and Sherril[2] studied salt restriction in arterial hypertension. In 1925, Allen[3] speculated that the general restriction of salt intake would probably lead to a decreased human morbidity and mortality from "renal-vascular" disease.

By the late 1920s, various sodium-restricted diets were being employed. The degree of success varied greatly from study to study.[25] The search was continued for a diet low in sodium that was also palatable and consistently effective. Many dietary expedients were considered, such as the beer diet, the use of exchange resins, and the employment of salt substitutes. A somewhat controversial but highly effective regimen was the rice-fruit diet popularized by Kempner[4] in 1944. The diet was low in sodium, cholesterol, and protein. Unquestionably, the diet proved effective in many patients with hypertension; but it was monotonous and unpalatable, and hence difficult to follow for a prolonged period. Furthermore, it provided only 20 gm of protein, dangerously under the minimal daily requirement for protein of something less than a gram/kg body weight/day.[8]

Between 1945 and 1950, several careful studies documented the effectiveness of sodium restriction in hypertension. Most reported an excellent response in about one third of the patients, a moderate response in one third, and little or no response in one third. Dahl[29] suggests that inconsistent results occurred because most of the patients were not actually on low-sodium diets—which, incidentally, is a primary thesis of this paper. Dahl stated, "In my own experience, which has been exclusively by referral, I have never, I repeat never, seen a new hypertensive patient who was, in fact, on a low sodium intake, all protestation to the contrary notwithstanding. I cannot believe this observation is unique to the patients I have observed."

Pinpoints Key Role of Salt

Dahl, who began his studies of salt and hypertension in 1948, presented in 1954 the first human data implicating sodium as a cause of hypertension. His studies indicated that there would, in all probability, be a significantly higher incidence of hypertension in persons who usually eat a high-salt diet than among those whose salt intake is low.[12,13] In 1956 and 1957, Dahl extended and confirmed his previous observations.[15,16,17] Since then he has published many other papers on the subject. Dahl is unquestionably the greatest long-term contributor to the study of sodium as it relates to hypertension. A review of his works over the years leaves little question about the key role of salt.

Despite the reports of Dahl and others before him, most clinicians observed little or no response to low-sodium therapy in their own patients—probably because, as Dahl[29] stated, the patients were not actually on low-sodium diets. As a result, few physicians really believed that sodium had much to do with hypertension and other diseases until the thiazide diuretics were introduced in 1957. Their effects on blood pressure were often so dramatic that the doubting clinicians could no longer deny the role of sodium in hypertension; they enthusiastically endorsed the use of diuretics in treatment and attributed the therapeutic response chiefly to the increased excretion of sodium. With the development of increasingly potent and easily administered diuretic agents, the already limited interest in other means of reducing bodily sodium content, particularly via the sodium-restricted diet, diminished even further.

As is all too well known, valuable though diuretics are, they sometimes cause untoward reactions. The rather formidable list includes sensitivity manifestations, hyperuricemia, hypokalemia, hypercalcemia with hypophosphatemia, hyperglycemia with glycosuria (in latent diabetics) and many others. Then there are minor but still bothersome problems—such as nausea, drowsiness, fatigue (sometimes profound), dizziness, and various skin disorders. Another point deserves mention: some individuals, because of personal circumstances, find that the active diuresis produced by diuretics is undesirable. (Such diuresis does not occur with the sodium-restricted diet.) The patient who cannot or will not take potent diuretics because of one of these reactions can do quite well on a sodium-restricted diet. Moreover, there is reason to believe that a more sustained level of the serum sodium

will be achieved, without the fluctuations that accompany the relatively high sodium intake of a normal diet alternating with more or less profound drug-induced diuresis. A further point: the long-term side effects of modern diuretics are not all known; the individual on a sodium-restricted diet will not have to worry about these unknown side effects.

Value Rediscovered Recently

In recent years, clinicians have rediscovered the value of sodium restriction in the treatment of a number of ailments, including not only hypertension, but congestive heart failure, nephrosis, cirrhosis of the liver, acute glomerulonephritis, Meniere's syndrome, premenstrual tension and toxemia of pregnancy. The clinical manifestations associated with most of these disorders are produced by abnormal retention of sodium and water, with or without frank edema. A fundamental objective of treatment is to reduce the extracellular fluid volume to normal. This can be accomplished by sufficient restriction of sodium to create a negative sodium balance that will result in diuresis and a subsequent decrease in the accumulated sodium and water. The degree of restriction needed to produce a negative sodium balance varies from individual to individual. It depends largely upon the previous intake and the severity of the disease process.

Hypertension. It is widely recognized that hereditary factors largely determine whether a given individual will develop hypertension, especially essential hypertension. However, researchers have induced uninherited but life-long hypertension in experimental animals by feeding them a high-salt diet.[34] The mechanism by which sodium produces hypertension is still controversial. For many years it was believed that hypertension develops as a direct result of increased extracellular fluid volume, with sodium acting as the volume holder.[27] However, recent evidence suggests that yet another mechanism is involved. Janovsky, et al.[21] have demonstrated that when salt is given in excess, much of it is retained outside the extracellular fluid compartment. They postulate that the storage site is in the walls of blood vessels, and that sodium bound to cellular structures renders the vessels of the arterial circulation excessively sensitive to the action of the catecholamines, such as epinephrine and norepinephrine. Burks, et al.[25] support this theory. They present evidence that arteries containing excessive quantities of sodium do indeed reveal an exaggerated response to vasoconstrictor stimuli. Thus, the rationale for the use of the sodium-restricted diet in the treatment of hypertension is obvious: not only should it reduce the extracellular fluid volume, it should also limit the amount of sodium available for binding to cellular structures.

Let us consider the relationship of renin to sodium and to the development of hypertension. Renin is a substance produced by the juxtaglomerular apparatus when renal circulation is impaired. Such impairment is produced by shock, by arteriolosclerosis, by arteriolovasoconstriction resulting from sympathetic nervous system stimulation as a psychosomatic effect, or from renal artery constriction, equivalent to clamping off the renal artery in one kidney of an experimental animal. The chain of events that follows would be beneficial in the case of shock, but disastrous in most other circumstances. Thus, given impairment of renal circulation, the juxtaglomerular cells increase their production of renin. Renin unites with a plasma globulin to form angiotensin. The latter has two effects, both productive of elevated arterial pressure. First, angiotensin of itself promotes generalized constriction of blood vessels. Second, angiotensin stimulates the production of excessive amounts of aldosterone. One of the effects is an increase in extracellular fluid volume through the retention of sodium. This forces sodium into the vascular walls, as above described.

An important category of patients with essential hypertension who do not suffer from primary hyperaldosteronism has shown low renin values. The group comprises at least 20% of all hypertensive patients.[33] These patients manifest normal aldosterone production. The diagnosis of hypertension accompanied by suppressed plasma renin activity is based on the failure of plasma renin activity to exceed 1.67 ng/ml/hr following treatment with 40 mg orally of furosemide at 6 p.m., 12 midnight, and 6 a.m., then assumption of upright posture for three hours. Seventeen patients with low-renin essential hypertension thus established were studied in a double-blind comparison of the therapeutic effect of spironolactone with that of a hydrochlorothiazide-triamterene combination. All of the patients responded to spironolactone with an average minimum decrease in blood pressure of 20.7 mm Hg. Fourteen responded to hydrochlorothiazide-triamterene with an average minimum decrease of 17 mm Hg. The difference in minimal blood pressure response was not statistically significant.

May Be Key Factor

The effectiveness of both forms of therapy, despite their different mechanisms of action, suggested to the authors that extracellular fluid volume reduction may be the key factor in relieving hypertension in patients with low-renin essential hypertension. Since one of the chief accomplishments of a severe low-sodium diet (about 250 mg—about 11 mEq*—of sodium) is reduction of extracellular fluid volume, low-renin essential hypertension is a valid indication for such dietary sodium restriction.

Congestive Heart Failure. There is general agreement that the retention of salt and water that accom-

*To convert mg sodium to mEq sodium, multiply mg by .0435. To convert mEq sodium to mg sodium, multiply mEq by 23. To convert mg sodium chloride to mg sodium, divide by 2.52.

panies congestive heart failure is responsible for many of the symptoms of the disease. As the disease progresses, with lessening of the efficiency of the circulation, venous stasis and decreased venous pressure prevent movement of sodium and water from the interstitial spaces to the bloodstream for delivery to the kidneys for excretion. With poor circulation, blood flow to the kidneys is diminished and kidney function is impaired. Aldosterone (which promotes sodium retention and potassium excretion by the kidneys) and the pituitary antidiuretic hormone ADH (which controls reabsorption of water) are out of balance and contribute further to the production of edema. Lowering the dietary sodium intake will decrease the amount of sodium circulating in the blood. Consequently, sodium —and therefore water—will be drawn from the interstitial spaces back into the bloodstream and eventually will be excreted by the kidneys, thereby relieving the edema. Diuretics aid in this process.[19] Some degree of sodium restriction is beneficial even in the patient who has only minimal cardiac failure, since a high salt intake by such a patient may produce frank clinical cardiac failure.[7]

Nephrotic Syndrome. While many factors play a role in causing the nephrotic syndrome, edema is the most prominent finding on physical examination.[26] The greatly decreased osmotic pressure of plasma and concentration of serum albumin certainly contribute to the development of generalized edema in this ailment. Nevertheless, there is considerable evidence that retention of salt and water also plays a role.[7] Sodium restriction will induce diuresis and may prevent reaccumulation of edema fluid. Hence, sodium restriction represents an important adjunct to the treatment of the nephrotic syndrome.[7]

Cirrhosis of the Liver. Among the complications of liver failure are renal salt retention (possibly related to excessive production of ADH), plus edema and ascites. Sodium restriction may prevent the further accumulation of ascitic fluid, or it may help to produce diuresis.[7] Once the ascites has been relieved, the sodium-restricted diet may prevent or delay its recurrence.

Acute Glomerulonephritis. Almost invariably, edema is associated with acute glomerulonephritis. At first it may be seen only as puffiness of the face and eyelids. Later, it appears in dependent parts or even becomes generalized. Moderate hypertension is common; extreme hypertension with encephalopathy and papilledema may occur. Some degree of congestive failure may develop from circulatory overload due to renal fluid retention. When edema or severe hypertension are present, sodium and water restriction alone or in conjunction with diuretics serves a useful purpose.[26]

Meniere's Syndrome. Meniere's disease or syndrome is seen not infrequently in the second half of life, sometimes before. Although many theories have been suggested to explain the basic disturbance of the labyrinth, the ultimate cause remains unknown. The disease is associated with degenerative changes in the membranous labyrinth and swelling of the canals, which result in paroxysms of vertigo lasting hours or all day, often associated with pallor, prostration, vomiting, slight mental confusion, pain behind the ears, and headache. A sodium-restricted diet is often prescribed to control the edema that produces the vertigo and the resultant symptoms.[28]

Premenstrual Tension. Many women develop premenstrual tension five to ten days preceding the menstrual period. Edginess, irritability, profound emotional swings, insomnia, headache, vertigo, nausea, edema, sore breasts, and in some patients, severe depression, characterize the syndrome. Studies have revealed that many of the crimes committed by women occur during the premenstrual period. While psychologic factors may play a role, abnormal retention of salt and water have been indicted. A sodium-restricted diet plus diuretics has been shown to relieve the edema usually associated with premenstrual tension. It may well be that the striking psychologic symptoms of the syndrome will also be relieved by a sodium-restricted diet.

Toxemia of Pregnancy. The origin of toxemia of pregnancy is unknown. Nevertheless, abnormal sodium retention and generalized vasoconstriction explain the signs and symptoms. Control of weight gain and limitation of sodium intake do not appear to decrease the incidence of preeclampsia, and hence eclampsia. Although patients with preeclampsia retain water and sodium, weight gain does not appear to cause preeclampsia. Endocrine or metabolic disorders, or both, or even other factors may well be implicated in the genesis of this fearsome disease.[34]

Signs of the onset of toxemia include: edema, not only of the ankles, but also of the hands and face; hypertension; and, in some patients, proteinuria. More advanced symptoms include generalized edema, headache, visual disturbances, abdominal pain, oliguria, nausea and vomiting. This constitutes a cluster of symptoms that warns of approaching eclampsia. With eclampsia, death can occur during a convulsion, or it can result from cerebral hemorrhage, congestive heart failure, or kidney shutdown.

An important element of therapy of eclampsia is sodium restriction, certainly to less than 2,000 mg sodium daily.

Application of the Sodium-Restricted Diet

In general, three degrees of sodium restriction have been employed —mild, moderate and strict. Diets may be ordered in mEq or in mg, depending, of course, on the physician. Mild restriction allows 100-200 mEq (2,400-4,500 mg) of sodium daily. Moderate restriction allows a daily sodium intake of 43 mEq (1,000 mg). Strict sodium restriction limits the daily allowance to not more than 23 mEq (500 mg).[31] To achieve a true therapeutic effect in many patients with es-

sential hypertension, it will be necessary to reduce sodium intake to about 11 mEq (250 mg).

Mild restriction is desirable for those patients whose condition requires some control of sodium intake without more stringent restriction. With mild restriction, the patient can eat foods that have been lightly salted during cooking. He should, however, add no salt at the table, and he should avoid salty foods.

In many patients, moderate restriction is indicated. In this instance, no salt can be added to food either during preparation or at the table, except that *either* ¼ teaspoon of salt can be used daily *or* sodium can be taken in measured amounts in such foods as regular bakery bread (of which one slice contains 150 mg of sodium) or salted butter (of which two teaspoons contain 100 mg of sodium) to make the diet more palatable. But no salty foods are allowed. In most cases, moderate restriction will increase urinary output sufficiently to correct an extracellular fluid volume excess.

If fluid retention persists despite moderate restriction plus medications, then strict sodium restriction is indicated. No salt is added during preparation of food or at the table, and salty foods are strictly prohibited. In individuals whose sodium tolerance is unusually low, severe sodium restriction (about 250 mg) may be necessary. This includes a great number of patients with so-called essential hypertension.

In their natural state most foods contain sodium. Animal foods, such as meat, poultry, fish, milk, cheese, and eggs, are relatively high in sodium. These foods, though nutritionally essential, must be used in measured amounts unless they have been processed to remove most of the naturally occurring sodium. Sodium can be removed easily from meat, fowl, fish (either fresh or salt water), and shell food by repeatedly boiling them in water.[8] The water should be decanted after each boiling. After the first boiling, which should continue for half an hour, the water need only be brought to a boil before decanting. The water used in the process should, of course, be low in sodium; otherwise, sodium will pass from the water into the food. This procedure is also effective in removing sodium from foods prepared according to Jewish dietary laws, which demand that meat be salted generously before use so that all traces of blood are removed from the surface of the meat.[10]

Fruits and most vegetables are relatively low in natural sodium. Some vegetables contain fairly large amounts of sodium, however. These include artichokes, beets or beet greens, celery, dandelion or mustard greens, kale, sauerkraut as prepared, spinach, Swiss chard, white turnips, and carrots.

But the chief source of dietary sodium is not that found in natural foods. Rather, it is the sodium added to foods during preservation and processing, during preparation, or at the table. For this reason, we must consider all these sources when a sodium-restricted diet is contemplated. The patient should, of course be instructed accordingly. Many patients are unaware of the large amounts of sodium added to foods in leavening agents, such as baking powder and baking soda; in compounds designed to enhance food flavor, such as monosodium glutamate; in preservatives, such as sodium benzoate, sodium propionate, and sodium sulfite; and as artificial sweeteners, such as sodium saccharin. In most of these instances, the sodium is not in the form of sodium chloride, hence the salty taste that many patients associate with sodium is missing.

Another source of sodium is water, for water supplies in different areas contain varying amounts of sodium. In areas where the water supply is high in sodium—i.e., greater than 0.87 mEq/L[22]—it may be necessary for the patient on the sodium-restricted diet to use only distilled water or natural water low in sodium. Well water is often high in sodium. Water softened with salt is always high in sodium and must therefore be avoided. Processed foods and beverages, including alcoholic beverages, reflect the sodium content of the water supply with which they are manufactured. Before the patient drinks these liquids, he should have them tested for sodium content.

In addition to the sodium in food and water, sodium can be ingested from other sources. For example, certain synthetic detergents used as dishwashing aids contain a much higher proportion of sodium than do true soaps, hence dishes should be rinsed thoroughly to remove all residue. Medications, such as sodium salicylate, cough medicines, antibiotics, sulfonamides, barbiturates, antacids, and laxatives, and dentifrices, such as toothpastes and mouthwash, may contain large amounts of sodium. The patient should be instructed to avoid all medications unless they have been prescribed or approved by the physician and to check all labels on dental products before using them.

A wide variety of specially prepared low-sodium foods is available in dietary shops and can often be found in the dietetic section of the supermarket. In general, these foods are upwards of three times as expensive as ordinary foods. Again, the patient should be cautioned to read the manufacturer's label on the product to determine that it is actually low in sodium. The terms *salt-free* or *prepared without salt* do not necessarily imply that the product is low in sodium. Carrots, for example, are not low-sodium vegetables even when prepared without salt.

Patients accustomed to eating a highly salted diet usually find a sodium-restricted diet difficult to maintain. Much can be done to alleviate the problem. Spices and herbs greatly enhance the flavor of foods and enable one to produce what is still a palatable diet, in spite of the difficulties presented by severe salt restriction. Most spices contain less than 0.05% sodium; all, except for allspice, celery seed, dehydrated celery flakes, dehydrated parsley flakes and whole mace,

contain less than 0.1%.[9] Such condiments as garlic salt are just as bad as any kind of salt, for they contain sodium chloride. Spices and herbs should be used sparingly—which, of course, is the proper way to use these valuable flavoring agents. The following are a few suggestions for foods and seasonings that are especially compatible:[24]

Beef: Bay leaf, thyme, marjoram, onion, dry mustard, parsley, dill, or herb butter.

Pork: Garlic, marjoram or sage.

Lamb: Garlic, onion, thyme, parsley, marjoram, mint, or rosemary.

Liver: Parsley, onion, chives, or herb butter.

Veal: Summer savory, chervil, marjoram, bay leaf, cumin, or oregano.

Poultry: Fresh or dried celery leaves, basil, marjoram, parsley, thyme or paprika.

Fish: Lemon, garlic, dill butter, chopped dill, basil, tarragon leaves or sweet butter.

Eggs: Chives, parsley, basil, marjoram, rosemary, tarragon, thyme, onion or mushrooms.

Asparagus: Chives, lemon, caraway, herb butter or sweet butter.

Carrots: Chives, parsley, mint or chervil.

Corn: Chives, parsley, green pepper, onion, tomato or chili powder.

Green beans: Dill, thyme, marjoram, nutmeg, onion, chives, scallions, rosemary, lemon, or unsalted French dressing.

Peas: Chives, mint, parsley, chervil, onion, mushrooms or lettuce.

Potatoes: Parsley, chives, onion, rosemary, mace or scallions.

Squash: Lemon, ginger, mace, basil, cloves, nutmeg, onion, green pepper or chives.

Tomatoes: Garlic, onion, parsley, basil, sage, chervil or tarragon.

Many salt substitutes can be obtained on today's market, either in grocery stores or in pharmacies. In general, they are crystalline preparations of potassium chloride.[7] Some have a number of spices added, and some are iodized. After the patient becomes used to the salt substitute, he will find that it is enormously helpful in making a sodium-restricted diet more palatable. Moreover, salt substitutes provide potassium that may well be needed, since individuals on a sodium-restricted diet may become deficient in potassium, especially if they are taking potent diuretics now and then. When used in moderation, salt substitutes are usually safe. However, the individual with impaired renal function should use salt substitutes only after obtaining permission from the physician.

It should be emphasized that some products used as salt substitutes contain considerable quantities of sodium. These products are classified as vegetized salts. Most of them have powdered dehydrated vegetables as a base and various additional ingredients.[31]

Dahl[29] suggests that another reason patients find the sodium-restricted diet hard to maintain is that most of the diets prescribed are so complex as to discourage all but the most persistent dieters. He offers the following useful rule of thumb for attaining a low-sodium diet that is both simple and effective:

"1) Never add salt to food during preparation or at the table, 2) avoid milk and milk products,* 3) avoid all processed foods except fruits and juices, and even here examine all labels. By using only this formula, a (calculated) week's menu with a daily average of 1,565 cal, 78 g protein, and 408 mg Na (~1g as NaCl) resulted. Calories may be increased, if desired, by adding sugar, jellies, bread (low Na, 2 mg/slice), fruits, and vegetables. Note that nothing is said about the usual proscriptions, e.g., lobster, shrimp, carrots, et cetera. All such foods were included but it was assumed that these would, on the average, not be eaten more than once a week. Like all rules of thumb, this one is not foolproof. Most people can remember these three rules and will end up on a far lower sodium intake than the usual regimen that is soon abandoned because of its complexity."

When Is the Sodium-Restricted Diet Hazardous?

For the individual with normal renal function, reduced intake or increased losses of sodium pose no serious problems since the body possesses a highly efficient mechanism for conserving sodium. Body sodium conservation is usually so effective that patients on a sodium-restricted diet seldom risk the danger of developing sodium deficit. Indeed, during the first days of a sodium-restricted diet, urinary excretion of sodium rapidly and progressively decreases until about the fifth day, when the losses of sodium are small (5 mEq or less daily) and relatively constant.[14]

However, diseases involving the kidney and certain of the endocrine glands may have a profound adverse influence on the sequence of events that take place in sodium conservation. In the patient with chronic renal insufficiency, for example, the sodium conservation mechanisms are depressed;[7] this may result in a negative sodium balance. If sodium intake is then decreased, the signs and symptoms of sodium deficit may be induced and the renal insufficiency aggravated. Profound adrenal insufficiency is accompanied by a failure to conserve sodium, along with an abnormal tendency to retain potassium. Certain brain lesions may of themselves induce sodium deficit.

But even though the regulating mechanisms are operating normally, abnormal losses of sodium—as from vomiting, diarrhea, exposure to heat, continued profuse sweating, the exudation of fluid from burned or other denuded areas, or the administration of potent diuretics—must be considered when sodium restriction is being planned. Especially hazardous is the combination of a low-sodium diet and powerful diuretics.

In the instances just mentioned, special care must be exercised to detect the early manifestations of

*Dr. Dahl might have added that low-sodium milks and cheeses are permissible, and also that it is usually permissible to use small amounts of regular milk, as in coffee.

sodium deficit. An early symptom of sodium deficiency is apprehension or anxiety.[28] The patient may suffer abdominal cramps. He may become weak, confused, perhaps even stuporous. Then he may experience a bizarre, undefinable feeling of impending doom. Later, cramps or much muscle twitching develop, and finally, convulsions may occur. Increased aldosterone secretion produces oliguria or anuria. As the sodium deficit worsens, vasomotor collapse occurs; the blood pressure falls, the pulse is rapid and thready, the skin is cold and clammy. Cyanosis may appear. One interesting finding is that of fingerprinting over the sternum; this consists of a visible fingerprint apparent after pressure is applied with a finger or thumb on the skin overlying the sternum. This finding results from increased plasticity of the tissues, which results from the transfer of water from the abnormally dilute extracellular fluid into the more concentrated cellular fluid because of the process of osmosis. Plasma sodium and chloride levels are below normal; the BUN may be elevated.

In-Hospital Study

In an effort to obtain practical insight into the problems of applying the low-sodium diet, an in-hospital study was carried out in two general hospitals and one nursing home.

Methods. In an effort to increase student knowledge of the sodium-restricted diet and of the nurse's role in dietary instruction, it was our initial intention to have sophomore baccalaureate nursing students assigned to care for patients receiving sodium-restricted diets to conduct interviews with their patients to determine 1) the frequency with which the sodium-restricted diet is being prescribed; 2) the conditions for which it is being prescribed; 3) how well the patients understood or failed to understand the diet; and 4) the effectiveness of nursing personnel in instructing the patient concerning the sodium-restricted diet.

The authors prepared a questionnaire designed to elicit the desired information. Students were to read the questions to their patients and record their responses. The patients were to be interviewed again following discharge to determine 1) to what degree they had adhered to the diet in the home setting, and 2) common errors in maintaining the diet at home.

This approach did not prove feasible, primarily because of mechanical difficulties involved in implementing it. The necessity of obtaining written permission from the attending physician before a patient could be interviewed proved a major problem; several of the physicians ignored the permission form completely, while others delayed signing it, so that many of the patients were discharged before the interview could be conducted.

Our plan to follow up on patients following discharge was abandoned, largely because of difficulties involved in getting the initial interview. Transportation also presented a problem, as many of the patients live in outlying areas or in other towns.

In the nursing home, most of the patients interviewed were elderly; many were senile. Because of the advanced age and decreased mental awareness of these patients, we felt their comprehension of the questions asked was such that any data obtained from them could not be considered reliable and, therefore, would not be significant to our study.

In view of these problems, we felt that one student, working through the dietary departments of the institutions, could more readily obtain the information we were seeking. Therefore, one student was assigned to gather data from the three institutions over a period of one month.

Results. At our request, the dietary department of one of the two hospitals recorded daily for a period of 54 days the number of patients for whom the sodium-restricted diet had been ordered. The daily totals ranged from 7 to 26, with a daily average of 17.

Medical data were collected on 37 hospitalized patients receiving a sodium-restricted diet. Following is a breakdown of the conditions that the *patients* named as the reason they were receiving the diet:

Heart disease	16
Fluid retention	7
Hypertension	3
Vertigo	2
Pulmonary edema	2
Diabetes	2
Kidney disease	2
Ascites	1
Viral Pneumonitis	1
Ulcer	1

Interviews were completed with 27 of the 37 patients initially contacted. When asked if they had received instruction concerning the sodium-restricted diet, 13 responded that they had received instruction either from their physician or from the dietitian; 6 had been contacted by both the physician and the dietitian. Five of the 13 said they had received follow-up instruction. Fourteen patients claimed they had received no instruction at all; some did not even know they had been placed on sodium restriction until their food arrived.

Of the 27 patients interviewed, only 2 said they knew the chemical symbol for sodium. Many of them appeared rather indifferent about the regimen and did not feel that strict adherence was important. (One patient listed his favorite snack as peanut butter and crackers, and only a few stated that they buy low-sodium foods.) A few relatives of patients were contacted, and their comments reflected the same general lack of understanding of the diet and of the importance of adherence as displayed by the patients.

In general, patient understanding of the sodium-restricted diet is poor. Instruction, if any, is often hurried and appears to be given at the convenience of the instructor rather than at the best time in accordance with the physical and emotional readiness of the patient to learn.

For example, the instructor may come in while the patient is receiving treatment or undergoing a test. Or, instruction may be attempted while the patient feels nauseated or is under sedation. Follow-up of the initial instruction is often inadequate. Usually the diet is explained, the patient is given a food list, is told to call if he has any questions, and the instructor leaves. Many patients hesitate to ask for further assistance for fear of being troublesome or being labeled ignorant.

Generally, we did not find nurses taking an active role in educating patients and helping them adjust to the sodium-restricted diet. Dietary personnel reported several instances when nurses did give information, but the information was inaccurate. More often, nurses gave no information at all, regarding the patient's diet as the sole responsibility of the dietitian.

For reasons stated previously, interviews were not conducted with patients at the nursing home. Information there was obtained primarily through discussions with the dietitian and by observing food intake by the patients. The general attitude toward the low-sodium diet appeared to be lax. Personnel indicated that since the elderly patients have little to look forward to and are often anorexic, foods relatively high in sodium (e.g., bacon) are frequently allowed, even though a sodium-restricted diet has been ordered. Physicians usually do not order sodium-restricted diets in a specific number of mg or mEq for these patients. Food for those on the sodium-restricted diet is prepared with the food for those eating a regular diet, then separated before seasoning. Once a month, patients are allowed to eat anything they wish. In addition, several patients were observed eating high-sodium foods brought to them by their families.

Recommendations. Obviously, patients need more adequate instruction concerning the sodium-restricted diet. It seems logical that nursing personnel should become more involved in this aspect of patient care. Dietary problems properly involve not only the physician and the dietitian, but the nurse as well, since it is the nurse's obligation to care for the "whole person." The nurse's knowledge of physiology, chemistry, nutrition and psychology provides an excellent theoretical basis for helping patients to interpret, implement and adjust to the sodium-restricted diet.

To fully implement the physician's instructions, both nurse and dietitian should understand the purpose of the sodium restriction and the degree of sodium restriction desired. Frequently, an order is written "low-sodium diet," with little or no specific direction. It is not stated whether the diet is a severe diet of 250 mg sodium/daily, or whether it is a more lax diet of 1,000, or perhaps 1,500 or 2,000 mg sodium/daily.

Since it is the nurse rather than the physician or dietitian who has prolonged contact with the patient, the nurse is often better able than anyone else to evaluate the patient's physical and emotional status. Hence, the nurse is able to select the most appropriate time for the initial teaching session and to alert the dietitian. Periodically, the nurse should attend an initial teaching session to refresh the memory as to what is being taught. By knowing what is being taught initially, the nurse can be more effective in reinforcing knowledge and correcting misconceptions later. It is also desirable for family members to be present during the teaching session since their understanding and acceptance of the diet often determines the success of the regimen after the patient goes home. Often, family members are absent when the diet is explained. If this is the case, the nurse should take the initiative to see that the diet is discussed with the patient's family when they are available.

In addition, the nurse should make every effort to see that all questions that the patient or his family may have about the diet are answered. If the nurse cannot provide the desired information, then the dietitian should be consulted. If the dietitian is off duty when questions arise, the questions should be recorded on the patient's chart so that nurses on other shifts will know to contact the dietitian. Additional questions may—and frequently do—arise after the patient has been discharged. In many such cases, patients hesitate to telephone the physician for instructions. Hence, patients should be encouraged to telephone the hospital dietary department when they need information. This service would not only benefit the patients, it would enable hospital personnel to evaluate their teaching program and to learn of areas that need greater emphasis.

Conclusion. The sodium-restricted diet is still a useful therapeutic tool—but only when it contains the amount of sodium recommended on the physician's order. Active cooperation by nurses, physicians and dietitians is necessary for truly effective teaching and implementation of the sodium-restricted diet. Without such indoctrination, the patient has little chance of understanding—much less, of maintaining—a regimen that could be so helpful to his well-being.

REFERENCES

1. Swift, J.: *Gulliver's Travels.* New York, Oxford University Press, 1971.
2. Allen, F.; Sherrill, J.: Treatment of arterial hypertension. *J. Met. Res.* 2:429-545, 1922.
3. Allen, F.: *Treatment of kidney diseases and high blood pressure.* Morristown, N.J., The Physiatric Institute, 1925.
4. Kempner, W.: Treatment of kidney disease and hypertensive disease with rice diet. *N. Car. M. J.* 5:125-133, 1944.
4. Stefanson, V., ed.: *Not by Bread Alone.* New York, Macmillan, 1946.
6. Eskew, G.: *The Fifth Element: The Story of a Basic American Industry.* Chicago, J. G. Ferguson, 1948.
7. Sokolow, M., et al.: Practical aspects of the low sodium diet. *Calif. Med.* 74:1-7 (Jan.) 1951.
8. Ornstein, G.: A very low sodium diet both palatable and variable. *J. Med. Soc. N. J.* 48:145-149 (Apr.) 1951.
9. Elvehjem, C.; Burns, C.: Sodium content of commercial spices. *JAMA* 148:1033 (Mar. 22) 1952.

10. Kisch, B.: Salt-poor diet and Jewish dietary laws. *JAMA* 153:1372 (Dec. 19) 1953.
11. Meneely, G.: Editorial: Salt. *Am. J. Med.* 16:1-3 (Jan.) 1954.
12. Dahl, L.; Love, R.: Relation of sodium chloride intake to essential hypertension in humans. *Federation Proc.* 13:426, 1954.
13. Dahl, L.; Love, R.: Evidence for relationship between sodium (chloride) intake and human essential hypertension. *Arch. Int. Med.* 94:525-531, 1954.
14. Davidson, C., et al.: Sodium-restricted diets: the rationale, complications, and practical aspects of their use. *JAMA* 156:1081-1083 (Nov.) 1954.
15. Dahl, L.; Love, R.: NaCl intake as related to human hypertension. *Federation Proc.* 15:513, 1956.
16. Dahl, L.: Evidence for increased intake of sodium in hypertension based on urinary excretion of sodium. *Proc. Soc. Exper. Biol & Med.* 94:13-16, 1957.
17. Dahl, L.; Love, R.: Etiological role of sodium chloride intake in essential hypertension in humans. *JAMA* 164: 397-400, 1957.
18. Dahl, L.: Salt intake and salt need. *New Engl. J. Med.* 158:1152-1157 (June 5) 1958.
19. Cooper, L., et al.: *Nutrition in Health and Disease*, ed. 14. Philadelphia, Lippincott, 1963.
20. Pike, R.: Sodium intake during pregnancy. *J. Am. Diet. Assoc.* 44:176-181 (Mar.) 1964.
21. Janovsky, M.; Martinek, J.; Stanincova, V.: The distribution of sodium, chloride and fluid in the body of young infants with increased intake of NaCl. *Biol. Neonat.* 11:261-272 (1967).
22. Newborg, B.: Sodium-restricted diet. *Arch. Intern. Med.* 123:692-693 (June) 1969.
23. Snively, W.; Thuerbach, J.: *Sea of Life.* New York, David McKay, 1969.
24. Mayer, J., ed.: Low-sodium diets. *Postgrad. Med.*, pp. 49-52 (July) 1971.
25. Burks, T.; Spalding, C.; Jones, V.: Influence of sodium and potassium content on arterial responsiveness. *Circ. Res.* 29:525-533 (Nov.) 1971.
26. Holvey, D., ed.: *The Merck Manual*, ed. 12. Rahway, N.J., Merck Sharp & Dohme, 1972.
27. Page, I., et al., ed.: *Review of Modern Medicine: Hypertension and the Cardiovascular System.* Minneapolis, Mod. Med. Pub., 1972.
28. Snively, W.; Beshear, D.: *Textbook of Pathophysiology.* Philadelphia, Lippincott, 1972.
29. Dahl, L.: Salt and Hypertension. *Am. J. Clin. Nutr.* 25:231-244 (Feb.) 1972.
30. Hopkins, B.; Taylor, R.: Sodium retriction in cardiac failure. *Med. J. of Australia* 1:370-371 (Feb. 19) 1972.
31. Krause, M.; Hunscher, M.: *Food, Nutrition and Diet Therapy*, ed. 5. Philadelphia, Saunders, 1972.
32. Page, I.: 'Common' salt and 'benign' hypertension. *Mod. Med.* 41:54-55 (Oct. 29) 1973.
33. Douglas, J.; Hollifield, J.; Liddle, G.: Treatment of low-renin essential hypertension: comparison of spironolactone and a hydrochlorothiazide-triamterene combination. *JAMA* 227:518-521 (Feb. 4) 1974.
34. Metheny, N.; Snively, W.: *Nurse's Handbook of Fluid Balance*, ed. 2. Philadelphia, Lippincott, 1974. ◄

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Peptic ulcer disease is a common health problem for which treatment has been modified over the past few years. This is a critical review of the surgical management.

The Surgical Treatment of Peptic Ulcer Disease—Critical Review of Results and Sequelae

DAVID A. FISHER
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Marion

THE following is a review of 67 cases of peptic ulcer disease treated surgically in the years 1968-1973. Of these 67 patients, 31 had been previously treated for peptic ulcer disease for varying periods of time. The highest incidence of peptic ulcers requiring surgical therapy occurred between the ages of 41-50 and the ratio of men to women was 1.68:1. (See Table I.)

The symptoms or findings displayed by these 67 patients ranged from varying degrees of epigastric pain to symptoms of obstruction and perforation. Seventy-seven per cent of the patients were suffering from abdominal pain. About 34% of the patients had gastrointestinal bleeding, evidenced by either hematemesis or melaena or both. Thirty per cent also suffered from vomiting, either related to their pain syndrome or to obstruction. (See Table II.)

It was found that 73.1% of the ulcers were duodenal and 26.9% were gastric. Of these 67 cases, 23 were reported to have had bleeding of varying degrees, and 30.6% of the patients with duodenal ulcers experienced bleeding, while 42.1% of gastric ulcer patients had some degree of bleeding. (See Table III.)

A variety of surgical procedures was performed. In 86.4% of these operations, the procedure consisted of a vagotomy combined with some other procedure as definitive ulcer treatment. The other 13.6% were treated with either a wedge resection for removal of the gastric ulcer, a simple closure of a perforation with suturing or oversewing, simple suture of a bleeding duodenal ulcer with pyloroplasty, or a bypass gastrojejunostomy for obstruction. A vagotomy with a Mikulicz type pyloroplasty was used in 32.8% of the operations. Procedures involving a partial gastric resection totalled 33 or 49.2% of the patients. Of these patients who underwent gastric resection for ulcer disease, 78.8% had a Billroth II type of gastrointestinal hookup and 15.1% had a Billroth I type of gastrointestinal anastomosis. (See Table IV.)

In 20 of the 67 cases, additional operative procedures were used for the treatment of other conditions. In 10 of the cases, cholecystectomy was done with the ulcer surgery, making a total of 14.9%. Nine patients or 13.4% underwent repair of an esophageal hiatus hernia. One

TABLE I

Age & Sex 67 Patients

Age	Male	Female	Total	Percentage
21-30	2	2	4	5.9%
31-40	13	4	17	25.4%
41-50	12	7	19	28.4%
51-60	8	7	15	22.4%
61-70	6	2	8	11.9%
71-80	1	2	3	4.5%
81 & over		1	1	1.5%
Total	42	25	67	Ratio 1.68:1

TABLE II

Pre-operative Symptoms or Findings—67 Patients

Type	No. of Patients	Percentage
Pain	51	76.1%
Vomiting	20	29.8%
Bleeding	21	31.3%
Obstruction	5	7.5%
Perforation	5	7.5%

TABLE III

Location of Ulcer—67 Patients

Location	With bleeding	Without bleeding	Total	%
Duodenal	15 (30.6%)	34	49	73.1%
Gastric	8 (42.1%)	10	18	26.9%

TABLE IV

Operative Procedure—67 Patients

	Procedure	Duodenal	Gastric	Total	%
1	Vagotomy, gastric resection and gastrojejunostomy (Billroth II)	21	5	26	38.8%
2	Vagotomy, pyloroplasty	18	4	22	29.8%
3	Vagotomy, gastric resection and gastroduodenostomy (Billroth I)	3	2	5	7.4%
4	Vagotomy, gastroenterostomy	2	1	3	4.4%
5	Closure of perforated ulcer without vagotomy	2	2	4	5.9%
6	Closure of perforated ulcer with vagotomy	1		1	1.5%
7	Subtotal gastrectomy	0	2	2	3.0%
8	Gastroenterostomy	1		1	1.5%
9	Wedge resection of ulcer	0	2	2	3.0%
10	Pyloroplasty, suture ligation of bleeding ulcer without vagotomy	1	0	1	1.5%

patient had an incidental appendectomy. (See Table V.)

In 27% of the ulcer cases, some type of postoperative complication developed. There were 17 different postoperative complications found in 17 patients, the greatest occurrence being pulmonary. Atelectasis or bronchopneumonia occurred in 5 patients.

Of the 67 patients who were operated on, only one died during hospital convalescence. This 64-year-old man was admitted with a chronic obstructive pulmonary condition and was also suffering from an untreated fracture of his right hip which he suffered about two weeks before admission. This man died 16 days postoperatively from an acute myocardial infarction. This made a very low percentage of 1.5% for operative mortality. (See Table VI.)

It was learned that 29.8% of the patients experienced some type of unpleasant side effects during their immediate postoperative convalescence. Of these patients, 16.6% experienced some degree of diarrhea. Only one patient was classified as having severe diarrhea. Three patients have continued to have persistent mild intermittent diarrhea requiring occasional medication for its control. The percentage of cases involving symptoms of dumping syndrome was 9%, again with only one case as severe. Dumping symptoms developed in 20% of the Billroth II patients, and none of the Billroth I patients experienced dumping. Another 21% of the patients suffered from varying degrees of pain, bloating, excessive weight gain or vomiting. The patient with excessive weight gain had a vagotomy and pyloroplasty. He is also the patient who developed a wound hernia, and this is probably related to his excessive weight gain. Most of the patients with dumping symptoms had undergone gastrojejunostomy. Although many of the patients suffered from more than one symptom, half of the patients who had undergone vagotomy and pyloroplasty experienced some postoperative discomfort. Of the 26 vagotomies and antrectomies performed, five experienced dumping and five had some postprandial vomiting for awhile. Most of the patients who encountered postoperative difficulties were relieved within a month or two by either natural course of their convalescence or with medication. (See Table VII.)

Two patients died within two months postoperatively of causes not related to their ulcer disease. This explains why only 65 patients were included in the postoperative follow-up.

In the last 18 months, GIA (gastrointestinal anastamosis) and the TA (thoraco-abdominal) surgical stapling devices were used for stapling the bowel and stomach when performing a resection, gastrojejunostomy or gastroduodenostomy. These devices were found very useful and reduced the operative time for these procedures considerably.

Use of these surgical staplers had an effect upon the recovery time and the healing of the wound. Although there were only 12 cases involving the use of these devices, we

TABLE V

Additional Operative Procedures—67 Patients

Procedure	No. of Patients	%
Cholecystectomy	10	14.9%
Hiatus Hernia Repair	9	13.4%
Appendectomy	1	1.4%
Total	20	29.7%

TABLE VI

Postoperative Complications

17 Patients

Type	No. of Patients
Abscess	1
Adhesions	2
Atelectasis	1
Cardiac arrythmia	1
Cardiopulmonary arrest	1
Dehiscence of wound	1
Esophageal stricture	1
Gastric atony	1
Gastric distention	1
Incisional hernia	2
Myocardial infarction	1 (died)
Obstruction	1
Bronchopneumonia	5
Superficial seroma	2
Suture line bleeding	1
Subphrenic abscess	1
Wound infection	1
17/67 Patients	1.5 mortality rate

TABLE VII

Postoperative Follow-up—65 Patients

Symptoms	Vagotomy & Pyloroplasty 22 patients	Vagotomy, resection Gastrojejunostomy 26 patients	Vagotomy, resection Gastroduodenostomy 5 patients	Total	Percent
Dumping syndrome					
Mild	1 (4.5%)	4 (15.3%)	0	5	7.6%
Severe		1 (3.8%)		1	1.5%
Diarrhea					
Occasional	4 (18.1%)	6 (23.0%)	0	10	15.3%
Severe		1 (3.8%)		1	1.5%
Persistent		3 (11.5%)		3	4.6%
Pain	2 (9%)	1 (3.8%)	0	3	4.6%
Bloating	2 (9%)	2 (7.6%)	0	4	6.2%
Excessive wt. gain	1 (4.5%)		0	1	1.5%
Vomiting	1 (4.5%)	5 (19.2%)	0	6	9.2%

were still able to calculate an average of eight days for the length of postoperative hospital stay in cases using these staplers. For the cases using suture for gastrointestinal repair, we averaged the cases which did not include complications, which could have lengthened the postoperative stay. This average was found to be 8.85 days, almost 1 full day longer than the cases involving the use of staplers, showing that the use of these machines did have an effect upon the length of postoperative recovery. The surgeons believe that postoperative convalescence is smoother and the patients are able to take diets better and more rapidly after having had stapling procedures, as compared to those who had undergone suturing procedures. (See Table VIII.)

Because this study covers only the cases done in the past five years, it is impossible to make a prolonged follow-up report. However, of the 67 patients who were operated upon in the past five years, 55 were listed to be doing well with no other problems relating to their ulcer disease. Of the other 12, one or 1.5% of the total patient population had a recurring ulcer problem which required more surgery; five or 7.5% had mild postoperative symptoms of dumping or diarrhea for a period of six months or more, and two have had reflux alkaline gastritis. One of the latter patients required surgery to direct the flow of bile and pancreatic juice away from the stomach with a Roux en Y jejunojejunostomy with a gastrojejunostomy limb.

In agreement with reports written by Drs. Small, Jahidi,[5] Savage, McVay,[4] and others who stated that they received best results from the use of vagotomy and pyloroplasty, this study shows that this procedure is a highly successful one for treatment of peptic ulcer. This study also shows that vagotomy, antrectomy and gastroduodenostomy is an equally successful procedure but with a slightly lesser occurrence of postoperative difficulties. The surgeons got an encouraging result of 82% for the number of patients who had good to excellent results, and a very low mortality rate of 1.5%, one case probably unrelated to the surgery.

Of the postoperative complaints, it appears that diarrhea was the most common symptom and was found in 18% with vagotomy and pyloroplasty, and in 28% of those who had vagotomy, resection and gastrojejunostomy. The diarrhea was generally of short duration and not a significant problem except in three patients or 4.4% of the total patient population.

It also appears that the use of the new surgical stapling devices has been a great asset by decreasing the amount of operating time. This study also seems to show an even better result for these staplers, in that the postoperative hospital stay is shortened and a smoother convalescence occurs.

In general, it seems that complicated peptic ulcer disease is becoming a much more manageable disease with the use of these procedures.

Remarks

This paper was written by a freshman premedical student at DePauw University in January 1974. He reviewed all the charts, read extensively to acquaint himself with the terminology and tried to gain some insights into the problems of peptic ulcer disease.

Although the paper is of very little scientific importance, it does reveal that a significant number of patients operated for peptic ulcer disease will have undesirable side effects for short periods of time, but most of these will subside spontaneously or can be controlled with diet and/or medication.

TABLE VIII

EFFECTS OF SURGICAL STAPLERS

Procedure	Average duration of post-op hospital stay (excluding complications)
Using Staple Machines	8.00 days
Using Sutures	8.85 days
Difference	.85 day

Conclusions

1) 67 patients were treated surgically for peptic ulcer disease and associated complications; 80.4% underwent vagotomy, 38.8% had a vagotomy and pyloroplasty, 4.4% had a vagotomy and gastroenterostomy, 37.2% had a vagotomy and antrectomy with a gastroduodenostomy (Billroth I), or a gastrojejunostomy (Billroth II) anastamosis.

2) 76.1% presented with pain, 31.3% had bleeding, 7.5% had evidence of obstruction from an ulcer, and 7.5% presented with perforations; 73.1% of the ulcers were duodenal and 26.9% were gastric ulcers.

3) Gastric ulcers (44.4%) were more likely to cause bleeding than duodenal ulcers (30.6%).

4) 14.9% of the patients had associated gallbladder or biliary tract disease, and 13.4% underwent hiatal herniorrhaphy at the time of definitive ulcer therapy. Only one patient had an appendectomy, since the surgeons shy away from doing incidental appendectomies with gastric surgery.

5) 25.3% developed postoperative complications of significant nature. None of these complications resulted in a mortality. The only death was in a very poor risk patient with a bleeding duodenal ulcer, untreated hip fracture and arteriosclerotic heart disease. He died of a coronary on the 16th postoperative day. Most of these complications were treated successfully without significant morbidity or sequelae.

6) Dumping symptoms occurred in 4.5% with vagotomy and pyloroplasty, and in 20% with vagotomy and Billroth II anastamoses. No dumping occurred in the five patients who had vagotomy and Billroth I procedures.

7) Diarrhea was the annoying symptom in 18% with vagotomy and pyloroplasty and in 27.8% of the patients with vagotomy and Billroth II type anastamoses. It was severe and persistent in three patients, requiring medication for control.

8) Stapling devices significantly decreased the operating time, seemed to promote better tissue healing and apparently shortened the hospital stay.

Although the writing of this paper has added very little to our scientific knowledge, it has accomplished the goal sought. Specifically, we wanted to give a young pre-medical student an opportunity to explore a common surgical problem in depth, to gather information and statistics from review of patient records and to gain an insight into the physiological basis of surgical practice. It was also designed to help him understand the importance of a good basic foundation in chemistry, zoology and physics in preparation for the study of medicine. We feel that we have accomplished this aim and that we can use the information learned from his report to help us inform and prepare future patients for undesirable symptoms which they might experience following ulcer surgery.

REFERENCES

1. Sleisenger, M.H.; Fordtran, John S.: *Gastrointestinal Disease;* Philadelphia, W. B. Saunders Co., 1973, pp. 476-689.
2. Davis and Christopher, *Textbook of Surgery,* David C. Sabiston, ed. Philadelphia, W. B. Saunders Co., 1972, pp. 817-855.
3. Gillespie, I. E.: Gastrin and Its Implications in the Management of Peptic Ulcer, *Disease-a-Month,* Aug. 1971.
4. Savage, L. E.; McVay, C. B.: Surgical Management of Peptic Ulcer. *Am. J. Surg.,* 119:191-195, Feb. 1970.
5. Small, W. T.; Jahidi, M. R.: Pyloroplasty and Vagotomy for Duodenal Ulcer. *Am. J. Surg.* 119:372-374, April 1970.
6. Price, W. E.; Grizzle, J. E.; Postlethwait, R. W.; et al.: Results of Operation for Duodenal Ulcer. *Surg. Gynecol. Obstet.* Aug. 1970, pp. 233-240.
7. Kaplin, M. S.; List, J. W.; Stemner, E. A.; et al.: Surgical Management of Peptic Ulcer Disease in the Aged Patient. *Arch. Surg.* 104:667-671, May 1972.
8. Eisenberg, M. M.; Woodward, E. R.; Carson, T. J.; et al.: Vagotomy and Drainage Procedure for Duodenal Ulcer. *Ann. Surg.* 170:317-328, Sept. 1969. ◄

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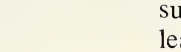
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PART I: VIROLOGY includes talks on epidemiologic implications for the viral etiology of cancer in man, and prospects for prevention and treatment of viral-caused cancer.

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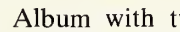
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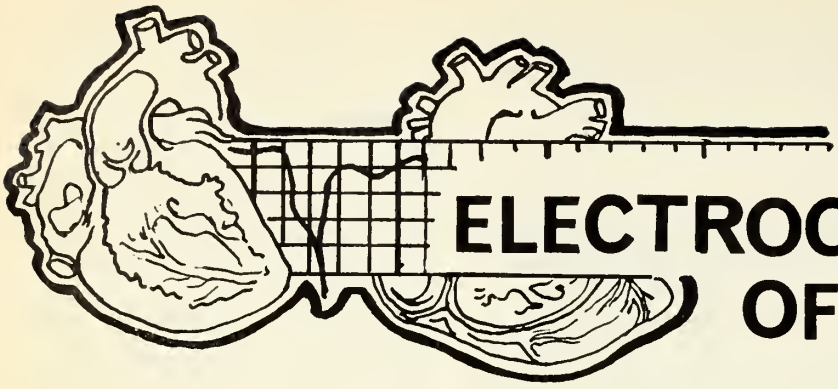
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ELECTROCARDIOGRAM OF THE MONTH

Paroxysmal Atrial Tachycardia with Block

JOHN C. BAILEY, M.D.
Indianapolis

THIS electrocardiogram was recorded from a patient who, in the distant past, had suffered an inferior wall myocardial infarction. At the time this record was obtained the patient was receiving digitalis because of the recent onset of congestive heart failure. Cursory examination of this electrocardiogram would suggest normal sinus rhythm. However, careful scrutiny of the PR segment in lead V_1 (where the P waves in this tracing are most evident) indicates that the P wave immediately preceding the QRS complex, with a PR interval of 0.08 sec., cannot give rise to the following QRS complex because normal conduction time through the AV junction requires 0.12 to 0.20 sec. In reality, the P wave giving rise to the QRS complex is buried in the T wave of the preceding QRS-T complex. Indeed, one can see the P waves deforming the T waves in lead V_1. Therefore, the true atrial rate is 200 beats/min and the ventricular response is 100 beats/min. This electrocardiogram, then, represents an instance of paroxysmal atrial tachycardia with 2:1 AV block in the presence of old inferior wall myocardial infarction.

The electrocardiographic features of paroxysmal atrial tachycardia with block are an atrial rate between 150 and 200 beats/min and a ventricular response that is always less than 1:1, that is, there is some degree of AV block. Vagal stimulation, such as carotid sinus massage, may increase the degree of AV block but will rarely terminate the tachycardia. Approximately 50% of cases of paroxysmal atrial tachycardia with block are due to digitalis excess, in which case it is imperative that the digitalis be stopped immediately. The remaining 50% of cases occur in the presence of various types of heart disease, and the arrhythmia in this circumstance may be treated appropriately with digitalis. In the case under discussion, when digitalis therapy was terminated, the patient reverted to normal sinus rhythm. ◄

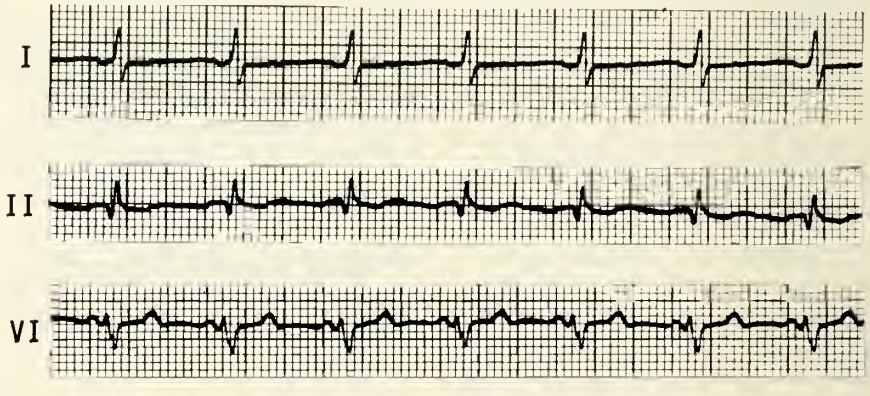


FIGURE 1

PAROXYSMAL atrial tachycardia with 2:1 AV block. The hidden P wave is buried in the preceding T wave.

From the Krannert Institute of Cardiology, Marion County General Hospital, and the Department of Medicine, Indiana University School of Medicine, Indianapolis 46202.

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Adverse Reaction Rates Low

ESTIMATES of the number of deaths annually in the U.S. due to adverse drug reactions have been numerous this year and have increased without reason every time the subject has been discussed.

An estimate of 30,000 deaths was presented to the Senate Health Subcommittee. Within a few months other "Authorities" had puffed the estimate up to 140,000.

All estimates were wrong.

The basic studies upon which the mortality figures are founded were made on acute medical services of teaching hospitals. Most of the fatalities occured in patients dying of malignancy or severe cardiovascular conditions—patients so ill that it was difficult to assign a specific cause of death.

The nationwide statistics were obtained by extrapolating the acute teaching ward experience to all hospital admissions in the U.S. Since the acutely ill patient with a drug-related reaction is most likely to be treated in a teaching hospital, it is obvious that such reactions and mortalities will not be characteristic of the general hospitals throughout the country.

The adverse reaction statistics have been repeated often, and sometimes with the implication that pharmaceutical industry promotional practices had induced the physicians to use the drug unwisely or in inappropriate circumstances. This is unlikely since a large proportion of the drugs involved in the reports were drugs such as digitalis and insulin which have been marketed for many years and are not the subjects for promotion.

In one Boston study about one-third of the deaths were attributed to the administration of potassium chloride, physiologic saline or dextrose in water—all substances not usually considered as dangerous.

A sober and unbiased review of the problem by many clinicians shows that the basic clinical data have been ineptly processed into a morass of misinformation. This is unfortunate since the public may become unnecessarily apprehensive concerning the use of potent drugs.

The public should know that the untoward effects of drugs are carefully monitored and when they occur are treated with respect. However, everyone should realize that the benefit-to-risk ratio of drugs is high, even in the case of the more potent examples.

State Medical Journals Head the List

STATE medical journals have received another vote of confidence from their readers.

This year, 10 of the state journals in the 36-journal group to which this journal belongs were tested by a professional research group in Philadelphia and set a record of which we may be very proud.

The testing mechanism, which is as objective as it is possible to be, consists of attaching valid bank checks for $5.00 to advertising pages and then counting the number of checks which are cashed within 10 weeks after mailing.

The journal copies to be decorated with the checks are selected by an independent certified public accountant. Physicians' names are chosen from the mailing list by serial numbers so that the selection is completely at random.

The checks are distributed through the various journal copies so that, in the end, each one of the advertising pages has been labeled as often as all the other ad pages in that issue.

During 1973 and 1974 our own state journal group and 16 of the most popular nationally distributed association sponsored and commercial medical publications have been tested by this technic.

The 10 state medical journals had an average score of 35%. This is an extremely high response. Usually returns on such tests are considered good if they are between 20 and 25%.

The scores for the other 16 national publications varied from 34.6% down to 15.4%. The state

journal group was at the head of the list.

Measuring a publication's ad-page-exposure record by the $5.00 check technic is the most reliable method yet devised. Every effort was made by the researcher to assure the highest standards of precision and accuracy. Standard procedures, without deviation, were employed on all journals.

The entire process is scupulously conducted so as to avoid bias. The results may be accepted as truly indicative of a publication's ability to attract and interest its readers, the physicians. All state journals may feel complimented and honored by such a study.

Corroborative evidence of the high readership of state journals is furnished by another type of reader interest study which was done by Medico Media Audit in June and July of this year. State medical journals as a group headed the list of the 10 publications which were studied.

These two readership audits are considered the most objective and most reliable of all the advertising surveys. The fact that state journals are at the top of each list indicates a consistency and reliability of a medical journalism medium which is most commendable.

If Not Medicine, Law

THE Sept. 7, 1974, issue of *Chicago Medicine* contains an article on Professional Standards Review Organizations (PSROs) by Betty Jane Anderson, J.D., director, Department of Health Law, Office of General Counsel, American Medical Association.

The tenor of Ms. Anderson's discussion is that, since the functioning of PSROs will inevitably and eventually define rather narrow standards of practice, the threat of malpractice suits and the difficulty of defending against them will increase manyfold.

Whereas today a malpractice defendant must be proven guilty of negligence, after PSRO is well established the plaintiff need only introduce the PSRO standards of practice to prove malpractice, despite absence of proof of negligence.

Ms. Anderson's estimate of the situation is well outlined in her concluding paragraph as follows:

> There is an old saying that every dark cloud has a silver lining. We, as lawyers, at least for the foreseeable future, will have more than enough to keep us busy. If your sons and daughters are not admitted to medical school, by all means, send them to law school.

Guest Editorials

Physician Assails New Law

To the Editor of The Star:

Politicians are not doctors, but a new Federal law gives politicians the power to tell your doctor how to practice medicine and to punish him if he doesn't follow their orders —no matter what he, as a physician, thinks is best for his patient.

Do you want politicians, not your doctor, deciding whether you need to go to a hospital, what hospital you can go to and how long you may stay?

Do you want your freedom of choice of a doctor taken from you by a Federal bureaucrat?

Do you want government employes snooping into your private medical records and telling other people what's in them—without having to burglarize your doctor's office? Remember the case of Daniel Ellsberg? Now it would be legal!

Do you want standardized, assembly-line cookbook medicine that compels your doctor to ignore the fact every individual is unique, that you might need to be treated differently than your neighbor?

The law which does all this is the Professional Standards Review Organization (PSRO). It is being forced on all doctors and on Medicare, Medicaid and disabled patients. The plan is to make it apply to everyone, including you.

Political medicine is bad medicine!

Help keep the bureaucrats out of your doctor's office and the politicians out of your private medical records! Write your congressmen and senators today urging them to support one of the bills designed to repeal the PSRO law.

HELEN B. BARNES, M.D.
Greenwood.

Published with the permission of Doctor Barnes as it appeared in the *Indianapolis Star*, Oct. 26, 1974.

All Students Need Career Education

EXPERTS figure that the supply of college graduates and the supply of jobs requiring them will remain in rough balance through the 1970s. But in the decade of the 1980s, the number of college graduates will far outstrip the supply of jobs for them.

Maybe it's time we all did some hard thinking about the purpose of an education.

Students need more exposure to the world of commerce and industry, and they need it early in the educational process. The buzzword for such exposure is "career education."

Career education means learning something about the nature and variety of skills needed by society. In the process, students should visit factories, stores and offices, and they should hear lectures from business executives, union leaders, civil servants and professionals.

An advanced education in the liberal arts should be pursued for its own sake, not solely as a ticket of admission to a management-trainee job. We should not take the snobbish and ignorant position that a college degree is "wasted" on someone who happens to prefer earning a living as an electrician, a plumber or a mechanic.

In most cases, the individual who works with his hands as well as his mind is quite free to wonder who wrote the plays of Shakespeare, how to trisect an angle, or why Napoleon invaded Russia. The popular philosopher Eric Hoffer became a part-time college professor on the

strength of what he taught himself while working as a longshoreman on the docks of San Francisco. Until he reached retirement age, he chose to remain a longshoreman.

College graduates would be making a big mistake not to consider work outside of the fields regarded as the traditional preserve of the degree holder. The skilled trades pay very well today; so do many technical fields. **— Arch Booth, president, Chamber of Commerce of the United States.**

EDITORIAL NOTES . . .

Dr. Edward Rynearson, now emeritus after a brilliant career at the Mayo Clinic, recovered recently from a fractured back. After watching TV talk shows day and night, he writes in *Nutrition Reviews* about his experience. The theme of his TV appraisal is "Americans love hogwash." He has reviewed the books on nutrition that were called to his attention on TV. Loaded with misinformation, fallacies, bum steers and dangerous advice is his conclusion.

Shortages now include chlorine. Due to a growth in demand and container shortages and transportation problems, chlorine for water purification is in very short supply.

Purdue Civil Engineering Highway Research associates give credit for the lowered highway accident mortality to the fact that, in addition to the lowered speed, passenger cars and trucks are traveling now, more nearly, at the same speed. Therefore, less passing and more car control.

It is amazing how often one encounters impossible combinations of recommendations for the remodeling of the U.S. medical service. Sometimes by people who should know better. A report by the Chamber of Commerce of the United States contains a statement of the Chamber's goal for medical service —"to assure that every American obtains reasonably priced, high quality medical care." No one, of course, would advocate excessive or unreasonable costs for medical care or anything else. However, when talking of high quality medical care everyone should remember that quality and cost go up and down together—high quality care is bound to be more expensive than mediocre care. The biggest reason for the present cost of medical care is its high quality.

A southern Illinois dairy firm prints the Illinois Health Department's recommended schedule of immunizations on its milk cartons—public service to help parents realize the importance of protection.

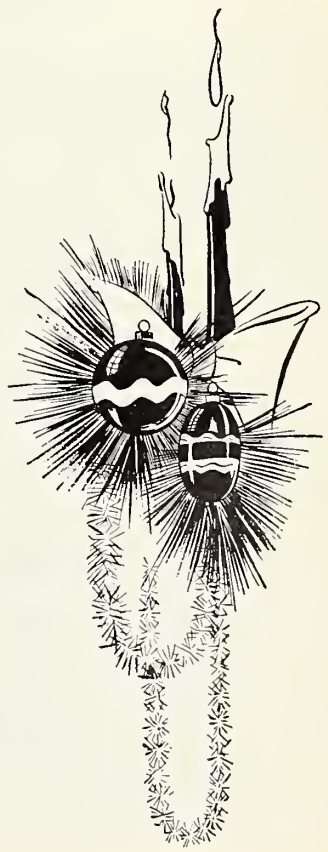
The Upjohn Company, together with Mt. Sinai School of Medicine and the Union Settlement Association, is developing a new approach to primary health care. The project, called the Modular Community Pharmacy, is designed to serve as a multi-purpose community health care facility for East Harlem in New York City. Specially trained pharmacists will be registered as physicians' associates and will evaluate patients, backed by supervising physicians at Mount Sinai.

Parke-Davis is investigating and doing the clinical testing of a vaccine for Pseudomonas infections. Use of either the vaccine or the use of gamma globulin produced from donors immunized by the vaccine has significantly improved mortality rates in severely burned patients and in patients with malignancies complicated by Pseudomonas organisms.

The computerized hospital information system of the Deaconess Hospital in Evansville is the subject of the lead story in COMPUTERS AND MEDICINE, a monthly publication of the AMA for the news about computers in medicine. Information in the system is protected against inappropriate or unauthorized access by an intricate system of controls. The system is praised for its adaptability; roughly 600 program changes have been made since it was installed.

The National Association of Retail Druggists has given its firm support for antisubstitution laws and regulations—basis: repeal would be detrimental to public health.

Dr. Clement J. McDonald, Indianapolis, has developed the use of a computer at the Regenstrief Institute to handle clinical records at three of the outpatient clinics. The initial abstracting of the patient's record is time consuming but after the computer is programmed a printout is available at each future clinic visit with all the pertinent information uniformly arranged. The system schedules lab tests in conformity with the drugs prescribed, i.e. Coumadin or insulin. Appointments, blood drawing list, prescription labels, inventory control and alerts for potential drug interactions are all automatically available.



Pinworm infestation is the most common human intestinal parasitic condition. Estimates are that one-tenth of the U.S. population (20,000,000 people) suffer from pinworms. The American School Health Association stresses that the old adages "Wash your hands" and "don't suck your thumb or bite your nails" are the best preventive measures. The disease cuts across all social and economic boundaries; should be looked for more often and especially in children.

Despite recent authoritative opinion that a real problem exists on bioavailability of a significant number of potent drugs, HEW is proceeding with its plan to reimburse its Medicare and Medicaid patients for all drugs at a reimbursement level below the usual price if the drug in any form may be obtained at a lesser cost. The only debate now seems to be how near the very lowest price the reimbursement level will be set. The only thing that has not been announced to date is the wording of the regulation that will make it the prescribing doctor's fault if the cheap drug is unsatisfactory.

The Veterans Administration reports that a new treatment, devised by a nurse, Mrs. Gladys C. Wallace of Louisville, has proven to be very effective in the treatment of decubitus and other types of slow healing ulcers. Karaya vegetable gum or karaya gum rings applied to granulating areas and covered with a well known plastic kitchen wrap has promoted healing to an unusual degree. Seven days for a superficial ulcer, 14 days for ulcers extending down to muscle, and 75 days for wounds involving muscle are the averages achieved. The June 1974 issue of *American Journal of Nursing* describes the therapy. No adverse effects have been reported to date.

The panel of experts reviewing adverse reactions to intrauterine contraceptive devices has reported that they find no significant differences between the experience with the Dalkon Shield and other such devices. They find that the mortality rate for the intrauterine device is between 1 and 10 deaths per million women years, while that for oral contraceptives is between 22 and 45 per million women years. The panel made a cautious recommendation that the Dalkon Shield be returned to the market.

A Wisconsin court has ruled that acceptance by a hospital of Hill-Burton funds does not necessarily obligate the hospital to perform abortions on request. The court ruled that the hospital could deny facilities to a physician performing abortions even though the institution was regulated by the state and received state and federal funds. ◄



DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Postpuberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250.

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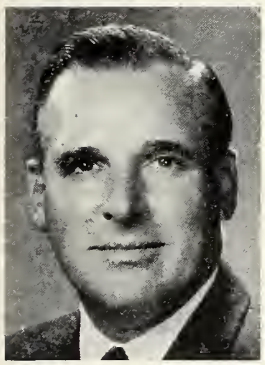
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REFER TO PDR

PSRO and Its Effect on Health Care Delivery

DONALD E. WOOD, M.D.
Indianapolis

IT is a pleasure to be a part of the 75th Anniversary of Methodist Hospital. We should take this opportunity to not only remember the past and pat ourselves on the back for our accomplishments up to this point but also to examine what lies ahead for this hospital and all of us involved in some manner in the health care of our community.



That is why I am limiting my remarks to PSRO and what it is all about. I'm sure most of us are somewhat familiar with PSRO but for the sake of the uninitiated, let me give you a brief description of it. I'll try to avoid unnecessary details and simplify the PSRO law but that's not easy . . . when you remember it was authored by Congress.

PSRO was signed into law on Oct. 30, 1972. While there is always an urge to express concern about the enactment of major legislation affecting the health field, such as Medicare, Medicaid, Comprehensive Health Planning and Regional Medical programs, it nevertheless seems likely that the impact of PSRO on the delivery of health care will be as great or greater than any law ever passed.

So, let us take a look at what a PSRO is, how it will be structured and how it might operate.

The purpose of the PSRO law is to create a nationwide network of physician groups to intially review medical services provided in institutions, both hospitals and extended care facilities, that are paid for under the provisions of the Social Security Act, that is: Medicare, Medicaid and Maternal and Child Health programs. Looking down the road, PSRO is obviously intended to later apply to ambulatory services too, and to other programs, particularly national health insurance, in whatever form it takes and whenever enacted. From now until Jan. 1, 1976, the law defines a PSRO as a nonprofit professional association or component organization with the following characteristics:

1. It must be composed of licensed doctors of medicine and osteopathy engaged in practice.
2. It must have as members a substantial proportion of the practicing physicians in the area.
3. It must maintain membership on a voluntary basis without restriction or dues.
4. It must be organized to allow for the review of medical services provided under the Social Security act.

If, after Jan. 1, 1976, no physician-controlled PSRO has been established for a particular area, the Department of HEW can designate some "other" organization to assume the PSRO's responsibility—that is, a public, non-profit, or private agency which could perform PSRO functions, such as state or local departments of health, medical schools, etc.

In reviewing medical services, a PSRO must determine three things:

1. Necessity of the services.
2. The quality of the services.
3. The appropriate level of care.

In establishing a basis for this evaluation, each PSRO must use professionally constructed "norms" of care, diagnosis and treatment, that are based on typical patterns of practice in its region, including typical lengths of stay for institutional care by age and diagnoses.

To assist PSROs in developing these "norms" of care, HEW has contracted with the AMA to coordinate a project with the national medical specialty societies in which each society would develop guidelines for diagnoses accounting for 75% of that specialty's inpatient care and publish them in document form by January 1976. An interim document will be published in the spring of 1975. These sample norms, in turn, may be adapted by the local PSRO if it doesn't opt to develop its own set of guidelines.

Although the PSRO has the legal responsibility to review medical care paid for under the Social Security act and provided within its boundaries, the PSRO may accept decisions from hospital and institutional peer review committees, as long as those committees are determined by the PSRO to be effective.

Although PSRO does not make payments for services, it does have the authority to approve or disapprove payment, and, consequently, has the authority to enforce its decision.

The law required the Department of Health, Education, and Welfare to designate PSRO areas prior to Jan. 1, 1974, which it has done, and to be prepared to accept, soon thereafter, applications from organizations in a designated area wishing to become PSROs, which it has also done.

Indiana has been divided into seven PSRO areas. Marion and 20 neighboring counties compose Re-

Presented at the 75th Anniversary observance of the Methodist Hospital, Indianapolis, October 21, 1974.

gion V and will work together in establishing the local PSRO.

One hundred and fifteen contracts have been awarded to organizations in 38 states, Puerto Rico and the District of Columbia in the following categories: 11 contracts for conditional PSRO status, 91 PSRO planning contracts and 13 contracts with state-level foundations and medical societies to act as statewide support centers. The Indiana Physicians Support agency here in Indianapolis has received a contract to serve the state in this capacity. And at this time organizations in two of our seven regions have received planning contracts: our Region V and the Lake County area.

The organizational structure of a PSRO is not described in the law, and regulations under the law dealing with the organizational structure are still in the developmental stage.

This past March, HEW issued the first seven of seventeen proposed chapters of the "PSRO Program Manual" which outlines the early operational phases of establishing a PSRO. Because there is no reason to get bogged down in details here, I won't delve into these regulations except where they will have an impact on us specifically.

The PSRO law requires those states containing three or more PSRO units to form a state PSRO Council which will include consumers as well as physicians to review the effectiveness of local PSROs. Indiana will necessarily establish such a council. The composition of the state council as spelled out in the law provides for:

1. One representative designated by each PSRO in the state.
2. Four physicians, two of whom may be designated by the state medical society and two of whom may be designated by the state hospital association.
3. Four persons knowledgeable in health care from the state who the secretary of HEW will select as representatives of the public, at least two of whom will have been recommended by the governor of the state.

The most important functions of the statewide PSRO Review Councils are to:

1. Coordinate and disseminate information and data to PSROs within the state.
2. Assist the secretary of HEW in the development of uniform data-gathering and operating procedures.
3. Assure efficient operation and objective evaluation of the PSROs within the state.
4. Assist the secretary in evaluating the performance of each PSRO.
5. Where the secretary finds it necessary to replace a PSRO, assist him in developing and arranging for a qualified replacement.

The law also provides for a national Professional Standards Review Council which has been appointed by the secretary of HEW and held its first meeting on July 9, 1973. The council consists of 11 physicians whose functions are to:

1. Advise the secretary on the administration of the program.
2. Provide for the development and distribution of information and data that will assist state PSRO Councils and individual PSROs in carrying out their functions.
3. Review PSRO operations in order to determine their effectiveness and comparative performance in carrying out the purposes of the program.
4. Make studies and investigations so as to develop recommendations to the secretary and the Congress on measures to more effectively accomplish the purpose and objectives of the program.

Basically, that concludes the overall look at the PSRO program. But, you may be asking, what does this mean to the hospitals? How does our hospitals or any hospital fit into the picture? Well, the PSRO law envisions two types of hospital review. If the hospital's own review committees meet the local PSRO's requirements, the PSRO can . . . and undoubtedly will . . . delegate the review functions of those committees, in which case the hospital medical staff will, in fact, be performing the review, although final responsibility still resides with the PSRO.

However, in hospitals whose review committees do not meet the PSRO's standards, the PSRO assumes direct responsibility for review of care in that hospital and the overall responsibility will be assigned to a physician not on the hospital staff.

Three types of review mechanisms will be initiated by the reviewing body and will become ongoing activities in the hospital. They are:

1) Concurrent admission certification and continued care review which will assess the medical necessity of a patient's admission and length of stay in the hospital.
2) Medical care evaluation studies.
3) Analysis of hospital, practitioner and patient profiles to retrospectively assess the quality and nature of the utilization of health care services performed.

Consequently, it is the hospital's decision as to the extent of involvement it wishes to have in the PSRO program.

There are, I would say, three ways you can describe the goals of PSRO:

1) You can consider it as a cost-control mechanism—and there is some justification for this in emphasis on not paying for unnecessary services and on requiring that services be provided in the most economical site which is medically appropriate—but I would not consider PSRO a success if it simply kept Medicare and Medicaid costs from increasing or slowed their rate of increase. You can do this without PSRO, and a lot cheaper; PSRO may, in actuality, increase the overall costs of the programs as the government begins picking up the cost of the review mechanisms.

2) You can consider it as a mechanism for weeding out the practitioners and providers who "abuse" the programs—but, again, PSRO seems an overly expensive and cumbersome approach, like using a bomb to get rid of mice in your cellar. In fact, in the present situation, when we have either a maldistribution or a shortage of physicians and when there may be only one hospital serving a given area, excluding a practitioner or provider from the federal programs may save tax funds—but leave the patient with the alternative of going to the excluded practitioner or provider, without any federal payment, or of going without care.

3) You can consider PSRO as a mechanism whereby the medical profession can identify the practitioners and providers who are providing less than optimum care and, through educational efforts, bring about improvement in that care until it is at the level it should be.

While the medical profession is concerned with the cost of medical care, its primary concern is the quality of the health care rendered. And if the joint cooperation of the medical profession and the federal government can establish a PSRO that will improve the quality of medical care, then the time and effort we give to this program will be well justified. ◄

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ABSTRACTS, BOOK REVIEWS

CORONARY ANGIOGRAPHY

H. A. Baltaxe, M.D., K. Amplatz, M.D., and D. C. Levin, M.D., Charles C Thomas, Bannerstone House, Springfield, Ill., 1974; 238 pages, profusely illustrated with angiograms, E.K.G.s, tables and diagrams; price not stated.

This is a beautifully put together volume telling, in minutest detail, the radiologist exactly how to proceed about the task of taking (but of course) coronary angiograms. It does not take exceeding perspicacity to realize that this "cookbook" will become must reading for radiologists and x-ray technicians.

The practicing cardiologist and even the G.P. cannot help but become enamored of the great wealth of coronary angiograms giving the non-expert a rather comprehensible overall view of what is ordinarily thought to be an arcane topic. If for no other reason, this book should grace the shelves of the libraries of hospitals, x-ray specialists, internists with a leaning to cardiology, and others.

The paper, binding and printing are superb. There are a few insignificant typographical errors. An excellent job; well done!

ARNOLD LIEBERMAN, M.D.
New York City

ATLAS OF VERTEBRAL ANGIOGRAPHY

Mutsumasa Takahashi, M.D., Director, Department of Radiology, Akita University School of Medicine, Akita, Japan, University Park Press, Baltimore, 1974; $39.50; 384 pages; 439 angiograms reproduced; some dozen and more tables and graphs.

This 12"x8½" volume is printed on the finest paper conceivable! The binding and type are truly superb. The material is presented to the reader with the briefest possible text that is a model of clarity. The Japanese are not only caught up with their peers in other lands—they are beginning to carve out a niche all for themselves!

As a "mere" internist, I've had ever more frequent occasions to stand by and watch the angiograms being taken on the path to a clear and definitive diagnosis. Certainly the knowledge explosion is so tremendous that we are doing things today routinely that were undreamt of even half a dozen years ago.

It is awe inspiring to watch diagnoses being made and confirmed by surgery and other means. Man's ever lengthening life expectancy is due in no small measure to the combinations of just such newly acquired knowledge as is so superbly illustrated by the contents of this volume. Congratulations to all involved!

ARNOLD LIEBERMAN, M.D.
New York City

AUTO-IMMUNITY AND AUTO-IMMUNE DISEASE

Sir Macfarlane Burnet, F. A. Davis Co., Philadelphia, 1972; $15.00; 242 pages with some tables and diagrams; abbreviations used are explained in a table; four-page glossary and the usual references.

The author of this well put together monograph is world renowned in his chosen field; but NObody can challenge his authority! This fact makes the careful perusal of this text all the more intriguing!

At the very beginning of this century, Paul Ehrlich discussed "horror autotoxicus": the immunological distinction between 'self' and 'not self' (p.59).

An enormous amount of research has been done in the intervening decades. We have learned to talk sagely about "tolerance and paralysis," "infection and auto-immunity," "pharmacological aspects of auto-immunity," "localized auto-immune diseases," etc. Multiple myelomas "may be" low grade malignancies arising from a myeloma clone (p.46): a monoclonal dysgammaglobulinemia. So: where do the T and B immune systems come in? Do we really know—as yet?

It is truly tantalizing to be told that systemic lupus erythematosus, rheumatoid arthritis (no less), Hashimoto's thyroiditis, the T and B cell systems and a host of other conditions may all be involved in these auto-immune processes! And now comes the humbling—ever so sobering—conclusion. For all our vaunted knowledge, we are still only at the very early stages of unraveling their basic convolutions and inter-related developments! Let us hope that the next decade (and more) will give us a truer insight into Nature's still hidden processes! And, on this sobering note, let us desist.

ARNOLD LIEBERMAN, M.D.
New York City

AROMATIC AMINOACIDS IN THE BRAIN

Ciba Foundation Symposium #22 (New Series), edited by G. E. W. Wolstenholme and David Fitzimons, Elsevier Publishing Co., 1974; 396 pages with numerous tables and diagrams; price not stated.

The usual couple-dozen experts under the chairmanship of Professor R. J. Wurtman of MIT contributed really learned essays to a still somewhat exotic but rapidly expanding area of neurological knowledge. The aromatic aminoacids in the brain are "only" three: phenylalanine, tyrosine and tryptophan. Without their presence, the brain just cannot function.

The present symposium delves into the still recondite area of just how nutrition, hormones and drugs affect their formation, uptake into the cerebral fluid and into the neurons themselves. The aminotransferases, the rates of hydroxylation, the regulation in adrenergic nervous tissues, the regulation of brain protein synthesis—these and many more are defined, described and followed through to the final de-amination—as far as presently possible.

This symposium is not light reading. The reader is assumed to be an expert in the field; he'd better be if he is to make any sense from the material! As usual, the printing, paper and binding are excellent. I'm sure that neurologists, hospital libraries and—mayhap—the internist, will enjoy having this volume on their shelves!

ARNOLD LIEBERMAN, M.D.
New York City

BIOCHEMISTRY OF BRAIN TUMOURS

M. Wollemann, Ph.D., University Park Press, Baltimore, 1974; $16.50; 193 pages with numerous figures and tables, voluminous references and an excellent explication of abbreviations.

This monograph comes from Budapest, Hungary, i.e., the other side of the iron curtain. Dr. Abel Lajtha is to be commended for the speed of the translation and the prompt publication in this country.

It may be that I'm becoming spoiled by the numerous volumes in this area that have come to my attention lately. I have referred to them previously. In either case, one gets the impression of a strictly interim report that may just become a definitive work, say five to ten years hence. The volume is in

three sections: "Introduction," "Pathochemical Changes in Brain Tumours" and "Metabolic Changes in Brain Tumours." There are some very crisp and clear summaries of what is known to date. For example: on page 79, there is a very model of brevity and clarity as "Terminal Oxidation" is presented to the reader. Again, on pages 104-105 there is a summation on catecholamine metabolism that cannot be caviled.

The paper, binding and printing are up their usual high standards.

ARNOLD LIEBERMAN, M.D.
New York City

PRACTICAL MANAGEMENT OF MENINGOMYELOCELE

Edited by J. M. Freeman, M.D., University Park Press, Baltimore, 1974; $18.75; 15 chapters with 240 pages; a dozen contributors.

This volume represents an attempt at a total overview of an all-too-common birth defect. Coming from the March of Dimes Birth Defects Center at the Johns Hopkins Hospital, it sets its sights high and seems to live up to them.

Being an internist myself, I realize that it has been a long time, indeed, since I've had occasion to see professionally this particular genetic deviation from the expected normal. This was all the more reason for my interest in leafing my way through its well printed and profusely illustrated pages. In the very first chapter, Dr. Freeman discusses the current terminology and lists no less than SIXTEEN variations under the all-inclusive title as given. I'm not embarrassed to say that many of the termins were brand new to me! I wonder if my younger colleagues—even those who are orthopods, pediatricians, neurosurgeons or just plain general practitioners—are really more knowledgable re the finer details?

The paper, binding and printing are up to the usual standards of excellence. Those called upon to manage this problem totally would do well to become thoroughly familiar with this monograph's contents.

ARNOLD LIEBERMAN, M.D.
New York City

THE MYOCARDIUM: FAILURE AND INFARCTION

Edited by Eugene Braunwald, M.D., in seven sections and 34 chapters, HP Publishing Co., Inc., 485 Madison Ave., New York, 1974; $17.95; 400 odd pages with innumerable diagrams, illustrations and tables.

Some 40 contributors have aided Dr. Braunwald in his formidable task of constructing de novo a teaching text designed to keep the clinicians and physicians in training abreast of the latest thinking on the etiology, pathogenesis, management and prevention of cardiac failure and arteriosclerotic coronary artery disease.

It is most interesting to note en passant that all these chapters had appeared originally in "Hospital Practice" over the preceding half-dozen-odd years. Each author thoroughly updated each item and Dr. Braunwald proceeded to integrate them into their proper niches.

This reviewer may be somewhat prejudiced, as he knew the editor many years ago at NIH; also, I had the great privilege of attending in November 1973 the joint USSR—USA meetings in Florida when Dr. Braunwald acted as the chairman of the American delegation. Be that as it may, this magnificent monograph, at its ridiculously low price is destined to become an outstanding textbook instructing the medical student as well as the professor of medicine.

Congratulations to all and sundry!

ARNOLD LIEBERMAN, M.D.
New York City

CRISIS INTERVENTION IN THE COMMUNITY

Richard K. McGee, Ph.D., University Park Press, Baltimore, 1974; 307 pages; $14.50.

The author of this intriguing volume is a psychologist who is the director of the Center for Crisis Intervention at the University of Florida at Gainesville. I spent several weeks recently at Ocala, Florida, a mere 30 miles by good highway from the University. I am truly sorry that I had been totally unaware of the very existence of Professor McGee until I found his book on my desk for purposes of a review.

Almost all M.D.s are aware of the fact of the 24-hour staffed telephone lines set up precisely for the distracted individuals contemplating suicide. We are (or should be) aware of the fact that human sympathy and a basic understanding of the schizoprenic motivations of the suicide-prone can be readily obtained not only by psychologists but also by intelligent paramedical personnel and—especially—by the readily trained laity.

Dr. McGee gives a clear description of the 200-odd presently existent centers. He details the role of the National Institutes of Mental Health and the financing furnished by NIMH.

It is my considered opinion that *ALL* M.D.s should peruse this volume. It is easy reading. At the same time, the problem is presented most succinctly and with a minimum of excess verbiage. Also, all city hospitals have this particular center telephone on their lists. It behooves *all* physicians to have this telephone number in their file ready for *immediate* use.

Dr. McGee gives space also for the follow-up service on the cases. This can be in the OPD or, better yet, by individual house calls by R.N.s or similarly qualified personnel. It is high time that our suicide rate started decreasing.

ARNOLD LIEBERMAN, M.D.
New York City

Continued



Abstracts from Various Literature, Prepared by AMA

EFFECT OF 15(R)15 METHYLPROSTAGLANDIN E_2 METHYL ESTER ON HEALING OF GASTRIC ULCERS

W. P. Fung et al. (S.M.M. Karim, Univ. Dept. of Obstetrics and Gynecology, Kandang Kerbau Hosp., Singapore)
Lancet 2:10-12 (July 6) 1974.

15 (R) 15 Methylprostaglandin E2 methyl ester was given orally for two weeks in doses of 150 μg six-hourly to ten Chinese subjects with proved gastric ulcer. The control group consisted of nine Chinese subjects with proved gastric ulcer without prostaglandin treatment. All were inpatients and were prescribed bed rest. Gastric ulcer healing was assessed endoscopically with a duodenofiberscope, Endoscopic visualization of the ulcer and color photography of the ulcer crater were undertaken just before and two weeks after treatment. In the prostaglandin group, complete healing was seen in three patients, considerable healing in six, and slight healing in one. In the control group, complete healing was seen in none, considerable healing in two patients, slight healing in four and no healing in three. This difference was highly significant. There was no significant difference between the two groups in the severity of ulcer or in age and sex distribution.

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ARNOLD H. KAMBLY, M.D.
Psychiatrist-Director

PNEUMATIC COMPRESSION OF CALF AND POSTOPERATIVE DEEP VEIN THROMBOSIS

W. B. Clark et al. (C. V. Ruckley, Univ. Dept. of Clinical Surgery, Western General Hosp., Edinburgh)
Lancet 2:5-9 (July 6) 1974.

The prevention of deep vein thrombosis (DVT) by intermittent pneumatic compression of the calf during and up to 24 hours after operation was studied by controlled trial. One leg of each patient was randomly allocated to treatment. DVT was diagnosed by ^{125}I-fibrinogen scanning. With a sequential statistical analysis, 36 patients were required before the 5% significance level was passed. Seven thrombi were detected in the control legs and none in the compressed legs. The study confirms that intermittent pneumatic compression is a safe and effective method of preventing early postoperative DVT.

THERAPEUTIC EFFICACY OF CROMOLYN SODIUM IN CHILDHOOD ASTHMA

M. B. Marks (333 Arthur Godfrey Rd., Miami Beach, FL 33140)
Am. J. Dis. Child. 128:301-304 (Sept.) 1974.

Cromolyn sodium is a new, inhaled medication useful in the control of severe chronic asthma in children. Its mode of action is prophylactic, in that it must be inhaled before the events precipitating the asthma attack occur. In an initial eight-week double-blind crossover study against placebo in severely asthmatic children, improvement in several parameters was found with the active drug in a majority of patients. These patients then began a long-term "open" study on cromolyn sodium therapy, which continued to be effective in mitigating asthmatic attacks in almost 50% of patients. Another 25% to 30% were able to reduce their total accessory drug intake and often converted from a daily to an alternate-day program of corticosteroid therapy. In addition, there was an overall improvement in exercise tolerance and a reduction in the incidence of exercise-induced bronchospasm. As in other reports in the literature, 20% to 25% of the patients failed to respond.

IDENTIFICATION OF WOUND INFECTION-POTENTIATING FACTORS IN SOIL

G. Rodeheaver et al. (R. F. Edlich, Univ. of Virginia Medical School, Charlottesville 22901)
Am. J. Surg. 128:8-14 (July) 1974.

Even the most trivial combat wound is regularly contaminated with soil. Unless this foreign body is adequately cleansed from the wound, the risk of subsequent infection is great. The causal factors for this deleterious effect of soil have, until now, been unknown. Results of this study have led to the identification of the factors in soil that potentiate the development of infection. When an injury contained as few as 100 bacteria, the addition of 5 mg of soil led to infection. When this soil sample was fractionated, it was found that the infection-potentiating factors (IPFs) resided predominantly in the clay or organic soil fractions or both. The type of cation adsorbed by the surface of the IPF did not influence its toxic effects on tissues. Silicate clay fractions contain several colloidal clay minerals: montmorillonite, illite, and kaolinite. Montmorillonite clay enhanced the development of infection more than did illite or kaolinite. The IPFs in organic and clay fractions of soil can be characterized by their large surface area and high cation exchange capacity. This physical property of the IPFs ensures an active chemical exchange between the wound and the IPFs

which may account for their deleterious effects. Isolation and identification of the factors in soil that potentiate infection will enable the development of techniques for the efficient removal of these agents based on modern pedologic methods.

CYTOTOXICITY OF VINCRISTINE TO NORMAL AND LEUKEMIC CELLS

R. Schrek (Northwestern Univ. School of Medicine, Chicago 60611)

Am. J. Clin. Pathol. 62:1-7 (July) 1974.

The in vitro toxicities of vincristine to nondividing lymphocytes from normal persons and from patients with chronic lymphocytic leukemia were measured by counts of viable lymphocytes and by the uptake of radioactive uridine. According to both methods, vincristine (0.1μg to 10μg/ml) produced in 18 hours a cytotoxic effect on leukemic but not on normal lymphocytes. The sensitivity of the cells was measured by D_{90}, the estimated concentration of vincristine that killed 90% of the cells in seven days. D_{90S} for lymphocytes from normal persons ranged from 7 μg to 27 μg/ml (median 10). The leukemic lymphocytes were more sensitive than the normal cells, with D_{90S} 0.1μg/ml to 19μg/ml, median 0.8. Vincristine was rapidly toxic to lymphoblasts from two acutely leukemic patients and to myeloblasts from two of eight patients. The data support the hypothesis of Boesen and Davis that the antitumor effect of vincristine is not dependent on metaphase arrest.

NONOPACIFIED GALLBLADDER ON ORAL CHOLECYSTOGRAPHY

Z. Mujahed et al. (New York Hosp.—Cornell Medical Center, New York 10021

Radiology 112:1-3 (July) 1974.

A retrospective review of 5,000 patients studied over a period of three years showed that a second dose was necessary in 25% of gallbladder examinations; however, third and fourth doses gave no additional information. Nonopacification of the gallbladder after a second examination is diagnositc of disease when all extrinsic factors have been ruled out. Intravenous cholangiography may show calculi in a diseased gallbladder that was not opacified on the oral study, since it does not depend on the concentrating ability of the gallbladder for opacification; however, a radiographically normal gallbladder on intravenous cholangiography does not rule out nonobstructive cholecystitis or cholelithiasis.

EFFECT OF DIFFERENT DOSES OF CHENODEOXYCHOLIC ACID ON BILE-LIPID COMPOSITION AND ON FREQUENCY OF SIDE EFFECTS IN PATIENTS WITH GALLSTONES

H. Y. I. Mok et al. (R. H. Dowling, Guy's Hosp. Medical School, London)

Lancet 2:253-257 (Aug. 3) 1974.

The effect of various doses of chenodeoxycholic acid (CDCA) on bile-lipid composition and the frequency of side effects were studied in 38 patients with gallstones. At a dose of 250 mg/day CDCA therapy did not reduce cholesterol saturation of bile in three of seven patients, but treatment with 500 mg CDCA/day or more led to a progressive desaturation of bile with cholesterol. While the response of bile-lipid composition to CDCA in individual patients was variable, the overall pattern of results suggested that the higher the dose, the greater the reduction in the saturation of bile with cholesterol. On withdrawal of CDCA therapy, bile-lipid composition reverted to its supersaturated state, suggesting that once gallstones have been dissolved, long-term maintenance or intermittent CDCA therapy may be necessary.

STAGING LAPAROTOMY IN HODGKIN DISEASE

M. J. O'Connell et al. (P. H. Wiernik, Baltimore Cancer Research Center, Baltimore 21211)

Am. J. Med. 57:86-91 (July) 1974.

Records of 99 consecutive previously untreated patients with Hodgkin disease subjected to laparotomy were used to assess the frequency with which inadequate or inappropriate therapy might have been administered on the basis of clinical staging alone. Of the 86 patients judged to be candidates for aggressive radiation therapy prior to laparotomy (clinical stage less than IIIB), unsuspected disease was found in the porta hepatis lateral to the margin of the usual para-aortic radiation field in four, and occult liver involvement in an additional two. On the other hand, two patients with clinically suspected hepatic involvement were found to be free of parenchymal disease and were therefore candidates for aggressive radiotherapy. Of particular interest was the discovery of occult abdominal disease outside conventional extended field radiation ports in three patients with clinical state IIA disease. It was not possible to reliably exclude the presence of occult disease outside standard abdominal radiation ports by previously published guidelines outlining indications for staging laparotomy. ◄

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The Woman's Auxiliary Reports to ISMA



I am happy to have a guest columnist this month who will discuss the need for better health education in our schools at the primary and secondary level.

She is chairman of our program extension committee on health education and is the wife of a Terre Haute physician.

Warmly,

Beth Bowen

Mrs. Otis R. Bowen, President

Dear Doctor:

Health education today is a subject much in the news and conversation. It is also, unfortunately, treated a great deal like the weather—much discussed but with the assumption that little can or needs to be done about it. You hear much about your responsibility as a physician to provide better preventive medicine, but find the general public wholly untutored in the necessary basics.

Health education might be defined as a serious academic discipline, seriously approached, that will establish an individual, personal consciousness toward health problems that will help to improve the quality of individual and community life. In the past, under the banner of health education, courses in the public schools have been presented as fragmented, individual spurts by persons whose teaching load needed another course and who were unqualified in almost every respect to teach the subject. Everyone remembers the rainy Friday afternoon segregated sessions in the school gym on the hazards of venereal disease—announced as health lectures. Everyone also remembers the comic quality and total lack of effectiveness of such "courses."

If properly approached and developed, a realistic health education program would serve as a basis for effective, far-reaching, preventive medicine which would ultimately provide improved general health for the population and would allow the physician to focus on the as yet non-preventable health problems. How can such a program be implemented?

First, it must be undertaken as a continuum, not as a series of haphazard, non-interdigitated studies. Second, it requires properly qualified instructors in the school systems whose primary function is effective, informed health education. Third, it must be a regular part of each year of the total primary and secondary educational system which uses each preceding year as a foundation and stepping-stone to the next year.

You, primarily, and we as your spouses, bear the responsibility for initiation of programs in our individual communities which can eventually result in legislative action at the state level. It is a personal responsibility and a pertinent cause for our energies.

Thank you,

M. Jan Keffer

(Mrs. Harry L. Keffer)

Headquarters' Page

New ISMA Staff Member—Bob Sullivan has joined the ISMA staff to handle internal and external relations. He is a retired Chief Journalist from the U.S. Navy and spent his last five years at the Defense Information School as an instructor in the Applied Journalism Department.

Now that I have been properly introduced, I would like to take this opportunity to say I am happy to be here and to explain what I expect to accomplish in your behalf.

First, I expect to keep you as well informed about current medical trends and legislative proposals as I can. In order to do this, I have written a letter to the AMA Public Affairs Division in Washington to keep me up-to-date on daily happenings.

Second, I plan to work with all the ISMA Committees and Commissions on all external public relations projects.

Third, I intend to write releases about the ISMA keeping the general public informed about what the ISMA is doing for them. This is where I will need your help. I can't tell the story if I don't know it myself. So please let your desires be known. If you have any suggestions for articles or ways I can be of any assistance to you in a public relations matter, please don't hesitate to call on me.

* * * * *

Following is a synopsis of two stories that appeared in The Journal of Commerce, Oct. 17, about malpractice.

Malpractice Coverage Examined—The National Association of Insurance Commissioners, zone one, met in Portland, Me., recently and examined the medical malpractice insurance crisis in depth as part of its two-day program.

While all present readily agreed a crisis does exist in the malpractice insurance field, A. John Smither, vice-president of Frank B. Hall & Co., said the medical profession, legal profession and insurance industry must all share in the problem.

He also stated the average doctor with his usual above-average income is a long way from being priced out of the malpractice insurance market. The cost of medical malpractice insurance is still a modest part of a doctor's income, he concluded. (Mr. Smither is associated with the Philadelphia office.)

Thomas Uehlin, director of professional liability risk management, St. Paul Insurance Cos., stated his company was trying to improve the malpractice climate through communication with the medical profession, computerized loss reports by type of claim and doctor, and research and exploration into new claims settlement approaches such as arbitration programs.

His company feels arbitration is a speedier system, is less likely to produce astronomical awards and results in a reduction in defense costs. Also, peer review is another area the company feels strongly about as an effective means of ascertaining the medical standards of defendant physicians.

Richard O. Barrett, assistant secretary Aetna Life & Casualty, stated patients have come to expect perfection from the medical profession. What the public needs is to be educated on the medical profession's limits. A combination of emotionalism and the legal profession is currently dictating the size of the claim awards, he concluded.

On insurance coverage, regulators will have to look at the overall marketing picture rather than attempting to get five or six companies in a particular state to write that state's medical association. A consortium arrangement also looms as another possibility, suggested Mr. Smither.

Malpractice Market Cited As Drying Up Fast—Time is running out for the retention of a free market for medical malpractice insurance, Waverly G. Smith, president of St. Paul Fire and Marine Insurance Co., told the otolaryngology section of the American Academy of Ophthalmology and Otolaryngology in Dallas recently.

Continued



"Relax . . . this is where his doctor lives, and Santa always stops to read his copy of The Journal of the Indiana State Medical Association."

Mr. Smith, whose company insures 40,000 doctors, urged doctors to "organize yourselves in every state . . . determine what your local legal situation is . . . then set a course of action to correct the problems you are facing." He said his company is eager to work with any group interested in solving the malpractice crisis.

"We must consider what remedial legislation is necessary to prevent the complete collapse of legal defenses," he said.

Some of the reasons for increased claims cited by Mr. Smith included less personal doctor-patient relationships, consumerism, greater patient expectations and the changes in court interpretations of negligence law.

Mr. Smith warned the medical group, "If the malpractice crisis cannot be solved it may develop that the only source of financial protection for you will be a government system."

He cited four major areas of law where such activity was needed: strengthening of the locality rule; restrictions on the statute of limitations; confidentiality of peer review group actions and establishment of standards for informed consent.

* * * * *

Governor Bowen Names Group To Propose Bill To Assist Doctors—A Committee to propose legislation for the next General Assembly to aid doctors who are losing or unable to get liability insurance has been appointed by Gov. Otis R. Bowen.

The story was carried in many papers throughout the state in conjunction with the information about Dr. Jack Hannah, anesthesiologist at Elkhart General Hospital, and the other two anesthesiologists there being notified by their carrier, St. Paul Insurance Co., it is refusing to renew all Class 5 risks in Indiana.

This type of story helps indoctrinate the general public about problems doctors are facing and why certain medical costs are increasing. It should definitely help when it comes time to get a bill through the legislature.

POSSIBLE CLOSING OF ANESTHESIA DEPARTMENT at Hendricks County Hospital was announced by Laurene E. Adair, C.R.N.A., chief nurse anesthetist at the hospital, because of increased cost of malpractice insurance for the Certified Nurse Anesthetist.

Maginnis and Associates, insurance consultants for the American Association of Nurse Anesthetists, announced an increase from $182 per year to $1,450.

* * * * *

Ford Pushed On Insurance—Frank Carlucci, No. 2 official at the Department of Health, Education, and Welfare, urged the President to make national health insurance compromises opposed by the medical profession, insurance industry and private business, according to a story by UPI.

One area mentioned was increased payroll taxes on workers and employers to provide health insurance benefits for families.

"Federal administration would be kept at a minimum and not necessarily in Social Security," said the memo.

It also mentioned the President's willingness to accept this compromise to HEW secretary, and recommended that he so indicate to Chairman Mills.

* * * * *

ACCORDING TO AN ARTICLE IN THE INDIANAPOLIS NEWS, Friday, Nov. 8, the Indiana General Assembly will be asked to consider closing three state mental health facilities and restaffing community centers in a vast reorganization of the Indiana Department of Mental Health.

The reorganization could be accomplished either by decentralizing the department, or establishing district hospitals, with each having its own board of directors, according to Arthur D. Little Inc., of Cambridge, Mass. The Little firm was hired by the Indiana Legislative Council to evaluate mental health programs in the state.

Any decision to close a hospital will have to be made by the legislature, according to Senator John M. Mutz (R-Indianapolis).

* * * * *

THE MICHIGAN STATE MEDICAL SOCIETY and a group called the Physicians Crisis Committee are seeking legislative and insurance remedies to combat the malpractice problem in Michigan.

* * * * *

AMA's Position On NHI Unchanged—A story appeared in newspapers recently that the AMA might switch its support to a compulsory health care program because of the recent congressional elections which swept too many supporters of their Medicredit program out of office.

According to an AMA spokesman this is not true. He said the AMA continues to oppose compulsory NHI because it feels each American has the "inherent and constitutional right of free choice."

He did state that the AMA is willing to consider a NHI program which would require employers to offer voluntary health insurance to their employees.

This is known as mandated national health insurance, not compulsory national health insurance, a point on which there seems to be considerable confusion. ◄

Annual Meeting Dates of Professional Medical and Allied Organizations

AMERICAN MEDICAL ASSOCIATION ANNUAL CONVENTION
Date June 14-19, 1975
Place Atlantic City, N.J.

INDIANA CHAPTER, AMERICAN COLLEGE OF SURGEONS
Date Apr. 30-May 3, 1975
Place The Greenbrier, White Sulphur Springs, W. Va.

AMERICAN ASSOCIATION OF MEDICAL ASSISTANTS, INC., STATE OF INDIANA
Date Apr. 25-27, 1975
Place Clarksville

AMERICAN LUNG ASSOCIATION OF INDIANA
Date Apr. 28-30, 1975
Place Marriott Inn, Indianapolis

INDIANA CHAPTER, ASSOCIATION OF AMERICAN PHYSICIANS AND SURGEONS
Date Apr. 6, 1975
Place Holiday Inn West, West Lafayette

INDIANA PSYCHIATRIC SOCIETY
Date Second Wednesday of September, November, January, February, March and April
Place For time and place, inquire Wesley A. Kissel, M.D., 1815 N. Capitol Ave., Indianapolis 46202

NORTHERN INDIANA PSYCHIATRIC SOCIETY
Date Fourth Wednesday of every month, September through June
Place For location and program, inquire Jon Leipold, M.D., 919 E. Jefferson Blvd. South Bend 46622

INDIANA STATE NURSES ASSOCIATION
Date Oct. 16-18, 1975
Place Atkinson Hotel, Indianapolis

INDIANA STATE MEDICAL ASSOCIATION CONVENTION
Date October 18-23, 1975
Place French Lick

INDIANA DENTAL ASSOCIATION
Date May 10-13, 1975
Place Indiana Convention-Exposition Center, Indianapolis

INDIANA ORTHOPAEDIC SOCIETY
Date Mar. 21, 1975
Place Michigan City

INDIANA ACADEMY OF OPHTHALMOLOGY AND OTOLARYNGOLOGY, INC.
Date Apr. 30-May 2, 1975
Place The Greenbrier, White Sulphur Springs, W. Va.

INDIANA HEALTH CAREERS, INC.
Date Apr. 10, 1975
Place Stouffers Indianapolis Inn

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TAX TIPS

by LAWRENCE A. JEGEN, III

Mr. Jegen is a professor of law at Indiana University Indianapolis Law School, specializing in taxatian, business assaciations and estate planning. Prafessor Jegen urges the reader to consult the reader's lawyer before applying the data in this article to a particular fact situation.

Retirement Plan Deductions

There is still time to establish a qualified retirement plan so as to provide yourself with federal and Indiana income tax deductions for the current year for the contributions which you make under the plan. The earnings on your contributions are exempt from income taxation as the earnings are earned, and there are some income tax advantages when the contributions and earnings are withdrawn from the fund at your retirement, either as a lump-sum distribution or as an annuity. If you intend to organize a professional corporation and utilize one of the qualified plans available to corporations, then you should discuss your situation with your lawyer, accountant, stock broker, insurance representative and banker. The least you should do is to write the Executive Director of any professional association to which you belong and ask him to send you any information which he has concerning qualified retirement plans which are available through the association. However, before you actually establish a plan, be certain to consult your lawyer as to the changes which were recently made by the "Pension Reform Act."

Year End Sale of Stock

Do you know what is the last day of 1974 on which a cash method taxpayer may sell corporate stock over the New York or American Stock Exchanges in order to have the gain or loss recognized in 1974?

Since a cash method taxpayer does not report gain until he actually or constructively receives the proceeds from a sale, the answer to the question for gain purposes is affected by the period of time that the stockholder has, under stock exchange rules, to deliver the cash to the taxpayer. The New York and American Stock Exchanges require the broker to deliver the proceeds within five business days after the sale date. Thus, a taxpayer may sell his corporate stock on or before December 23, 1974,* and recognize a gain in 1974. If the taxpayer sells his stock after that date, then his gain will be recognized in 1975, unless he requests that his broker accept a cash sale, in which case the sale could be made as late as December 31, 1974, because the broker would be required to deliver the cash to the taxpayer on the date of the sale.

If the cash method taxpayer has a potential loss on his stock, he is unaffected by the stock exchange rules concerning cash delivery. I.R.C. §165 allows a loss deduction in the year in which the loss is incurred, regardless of when the sale proceeds are received. Thus, if stock is sold at a loss as late as December 31, 1974, the loss must be recognized in 1974, regardless of when the proceeds are delivered to the taxpayer.

However before you sell any stock at a loss during 1974, remember that if you have an excess of long-term capital losses over your capital gains, then you may lose a deduction for 50% of the excess losses. Thus, if you can recognize any capital gains now in order to eliminate any of your present excess long-term capital losses, you probably should do so. Also, you should consider delaying the recognition of any more of your long-term capital losses until 1975, when you will have another opportunity to recognize some capital gains.

*Note—this date may be changed to an earlier date where, for example, the New York Stock or American Exchanges decided to close on an earlier date than they now plan to.

Subchapter S

If your corporation uses the calendar year as its taxable year, consider having it elect treatment under Subchapter S of the 1954 Internal Revenue Code for its taxable year beginning on January 1, 1975. To do so, the election statement (I.R.S. Form 2553) must be filed on or before January 31, 1975. In general, the shareholders also must file their consent statements on or before January 31, 1975. And, because of the recent changes concerning the amount of income on which a shareholder-employee will be taxed, due to a corporation's contribution on his behalf to a qualified retirement plan, it may be wise to elect Subchapter S. In any event, consult your lawyer now in order to have him determine the proper course of action for you and your corporation.

Tax Saving and Good Investment

If you think that you will be in an income tax bracket of 40% or more for 1974, then this tip is especially for you. Call your stockbroker, at once, and ask him to send you one or two prospectuses for investments in limited partnerships which are organized for developing and managing income producing real estate. If you invest, e.g., $5,000 in such venture, you could obtain, even at this late date, an immediate ordinary income tax deduction of $2,500. And, in a 40% income tax bracket you would save $1,000 of income taxes for 1974. Further, you will generally receive tax-free income of 7% to 9% (on your investment) each year in the future. When the venture ends, and the partnership liquidates, you probably will receive capital gain rather than ordinary income. ◄

From THE JOURNAL 50 Years Ago

Mesenteric cyst is a comparatively rare abdominal tumor which is, however, of sufficient frequency to demand consideration in differential diagnosis. When in 1905, Dr. O. G. Pfaff reported his second case, at a meeting of the Association of Obstetricians and Gynecologists, he stated that reference had been made to about 150 cases, since the first reference by Benevieni in 1507, which, like most of the others, was a postmortem finding. Since then Dr. Pfaff has seen two cases; Niosi in Virchow's Archiv reports 184 . . . .

The treatment of mesenteric cyst must always be surgical and will, of course, differ with the presence or absence of obstruction. In a case such as has been related, there are three possibilities—dissection, excision with the removal of overlying bowel, and marsupialization. Dissection might be possible in a small cyst with thick walls, but even so, the intimate relationship of the cyst wall with the mesenteric vessels would make this a precarious procedure. In the smaller cysts, excision of cyst and the bowel supplied by the vessels passing in contact with the cyst is, perhaps, the method of choice. The pathology is removed beyond the possibility of return, and the amount of bowel involved will not be considerable. But even so, a bowel resection and anastomosis is to be approached reluctantly and with trepidation. In the case reported, such a procedure would have been dubious. Many feet of bowel would have been removed and it would have been necessary to invade the pelvis with its plastic remains of unknown previous pathology. Marsupialization has the advantage of escaping the shock of resection and the leaky dangers of anastomosis, but is far from assuring that there will be no more recurrence. The outcome has not made me regret my decision. . . . Robert A. Milliken, M.D., Indianapolis, "Mesenteric Cysts," **JISMA**, December 1924.

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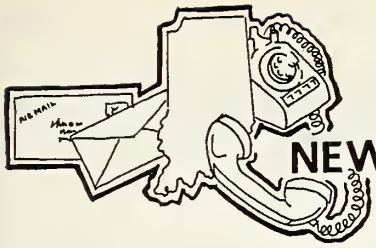
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13 Hoosiers Certified By Orthopaedic Surgery Board

The American Board of Orthopaedic Surgery has announced the certification of the following Indiana physicians in 1974:

Dr. Wade Rademacher, Beech Grove;
Dr. Rajih Y. Haddawi, Bloomington;
Dr. R. Anthony Marrese, Evansville;
Drs. William B. LaSalle and Michael L. McArdle, Fort Wayne;
Drs. William N. Capello, **Robert E. Cravens, and John C. Klein, Indianapolis;**
Dr. Jerrold E. Tomlin, Jeffersonville;
Dr. Stephen S. Choi, Kokomo;
Dr. John M. Gossard, Lafayette;
Dr. Raymond J. O'Brien, Michigan City; and
Dr. Alan J. Habansky, Muncie.

Fire Prevention Folders Available

The National Fire Protection Association announces an informative folder "You Can Prevent Hospital Fires" for employees of health care facilities. It is a two-color, six-page folder which will fit a standard No. 10 business envelope. It may be enclosed with paychecks or any other mail to employees. The price is $6 per 100, with 10% off for orders of 1,000 to 10,000 and 20% discount on larger orders. The address is 470 Atlantic Ave., Boston 02210.

Address Industrial Nurses' Conference

Physicians who addressed the 21st annual Fall Conference of the Indiana Association of Industrial Nurses included: **Dr. T. Forrest Fisher, Gary,** whose subject was "The Emergency Services Act and the Occupational Health Nurse," **Dr. Joseph Stratigos, South Bend,** who is chief of medicine and rehabilitation at the Veterans Hospital in Chicago, and **Dr. James C. Reed, Elkhart,** whose topic was "Occupational Dermatitis."

Dr. Tavel College Governor for Indiana

Dr. Morton E. Tavel, Indianapolis, is serving as College Governor for Indiana for the American College of Cardiology.

PMA Continues Research Fellowships

The Pharmaceutical Manufacturers Association Foundation is continuing its award program for Medical Student Research Fellowship. Four one-year grants of $5,000 will be given to students in the last three years of medical school who are interested in clinical pharmacology, who have the blessing of their own school, and who wish to devote a full year to specific research effort. Deadline for applications is January 15, 1975.

Heads Workshop on Sickle-Cell Anemia

Dr. George E. Branam, Muncie, conducted a workshop on sickle-cell anemia recently under sponsorship of the Head Start Program of Delaware County.

Presents New Film at Cine Clinic

Dr. John E. Jesseph, Indianapolis, presented a film on operating procedure at the 25th Cine Clinic at a recent meeting of the College of Surgeons in Miami Beach. The film shows the operating technic of gastric resection to illustrate the avoidance of complications. Cine Clinics are produced by Davis and Geck. The teaching series was started in 1927 and 416 films have been made since then.

County Health Board Elects

Dr. Paul Sparks, Winchester, was re-elected vice-chairman of the Randolph County Board of Health at a recent meeting, following his reappointment to a new four-year term. **Dr. C. R. Slick, Winchester,** also serves on the Board. **Dr. B. D. Wagoner, Union City,** was reappointed County Health Officer.

Health Care Safety File Offered

The National Fire Protection Association offers a Supplemental Library of Health Care Safety, consisting of 13 pamphlets in a desk file and selling for $28.50. It is complementary to the original 12-volume Basic Library of Health Care Safety. Thirty-six lives were lost by fire in health facilities in 1973. Standards included in the set deal with bulk oxygen systems, hyperbaric facilities, inhalation anesthetics, home use of respiratory therapy, etc., etc. Write to the Association at 470 Atlantic Ave., Boston 02210.

Elected to Professional Review Board

Dr. Theodore R. Espy, Gary, has been elected to the 14-member board of the American Association of Professional Standards Review Organizations. Dr. Espy has practiced in Gary since 1953. He is a graduate of Fisk University where he was elected to Phi Beta Kappa.

Continued

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SCHEDULE FOR UPCOMING NCME PROGRAMS

Here ore the ploying dotes ond upcoming progroms to be distributed by the Network for Continuing Medical Education (NCME):

Nov. 18-Dec. 1 — THE HAND AS AN INDICATOR OF SYSTEMIC DISEASE, with Morguerite Lerner, M.D., Clinicol Professor of Dermotology, Yole University School of Medicine, New Hoven, CT.

PARASITIC INFESTATION: SCABIES, with Silos E. O'Quinn, M.D., Professor of Dermotology ond Dean of Medicine; ond Harold Tropido, Ph.D., Professor of Tropicol Medicine ond Medical Parasitology, both at Louisiana State University School of Medicine in New Orleans.

IMPOTENCE, with Philip A. Sarrel, M.D., Associote Professor of Obstetrics ond Gynecology ot Yole University Medicol School, ond Lorno Sorrel, Co-Director, Humon Sexuality Progrom, Yale University Student Mentol Hygiene Department in New Hoven.

Dec. 2-Dec. 15 — SEX IN AGING AND DISEASE, with Philip A. Sorrel, M.D., Associote Professor of Obstetrics ond Gynecology ot Yale University Medical School, ond Lorno Sorrel, Co-Director, Human Sexuolity Progrom at Yole University Student Mental Hygiene Department, New Hoven.

MEDICAL ADVANCES INSTITUTE, with Jomes L. Henry, M.D., President of the Ohio Stote Medicol Associotion; Paul Y. Ertel, M.D., Director of the MAI Clinical Systems in Ohio; William A. Millhon, M.D., Chief Physicion Advisor, Riverside-Methodist Hospital, Columbus, Ohio.

FEMALE STRESS INCONTINENCE: DIAGNOSIS AND DECISION, with Vincent J. O'Conor, Jr., M.D., Professor of Urology, Choirmon, Deportment of Urology, Northwestern Memoriol Hospital, Chicogo.

(Progrom scheduling subject to chonge)

For more informotion obout NCME, write The Network for Continuing Medicol Educotion, 15 Columbus Circle, New York, N.Y. 10023.

Cancer Society Elects Dr. Ratts

Dr. Larry Ratts, Bloomington, was elected president of the American Cancer Society, Indiana Division, Inc., at the Division's 38th annual meeting in Indianapolis recently.

Drs. Blum, Brown Honored

The Vigo County Unit of the American Cancer Society recently awarded a Certificate of Merit and a marble paper weight to **Dr. Leon L. Blum, Terre Haute,** in recognition of the "quality and longevity of his service" to the Unit. Dr. Blum has been a member of the Unit board and chairman of the Union Hospital cancer committee since its organization in 1964.

Dr. Robert Brown, immediate past president of the Unit, was also recognized for his volunteer services.

Speaks on Cardiovascular Disease

Dr. Paul E. Schmidt, Indianapolis, was the speaker at the October meeting of the Crossroads of America Chapter of the National Secretaries Association (International). His topic was "Preventive Measures in Cardiovascular Disease."

Brooklyn Journal Editor Suggests Novel Malpractice Insurance Plan

The editor of *The Bulletin of the Medical Society of the County of Kings* (Brooklyn, N.Y.), suggests the possibility of one-shot single-risk malpractice coverage. This would be similar to one-flight insurance for an airplane journey. The patient could purchase the policy when admitted, whether for medical or surgical care. The malpractice risks of various operations and various medical conditions could be determined actuarially. Modifying factors might be applied depending on the doctor's certification or the safety rating of the hospital. ◄



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Indiana University Medical School Announces Postgraduate Schedule

Postgraduate and continuing medical education courses to be presented by the Indiana University School of Medicine in the coming months have been announced, as follows (all to be given at Indianapolis except where another location is mentioned):

Pediatric Gastroenterology Conference, Dec. 11-12, 1974, Joseph F. Fitzgerald, M.D., course director

Current Concepts in Cancer Chemotherapy and Immunotherapy, Jan. 15, 1975, Lawrence Einhorn, M.D., course director

Progress in X-Ray and Isotope Diagnosis, Jan. 23, 1975, Richmond, Paul S. Rhoads, M.D., course director

Ocular Histoplasmosis, Jan. 30-31, 1975, T. F. Schlaegel, Jr., M.D., course director

Fourth Annual Fred H. Priebe Memorial Symposium on Arthritis, Feb. 5, 1975, co-sponsored by Arthritis Foundation, Indiana Chapter, Edward R. Gabovitch, M.D., Anthony S. Ridolfo, M.D., course directors.

Everyday Dermatology, Feb. 19, 1975, Victor C. Hackney, M.D., course director

Diabetes Mellitus—Pathogenesis, Practical Aspects of Management, Feb. 27, 1975, Richmond, Paul S. Rhoads, M.D., John L. Cullison, M.D., course directors

Surgery Review, Mar. 6-7, 1975, co-sponsored by Indiana Chapter, American College of Surgeons, Robert E. Lempke, M.D., Peter B. Yaw, M.D., course directors

60th Annual Head and Neck Anatomical and Clinical Otolaryngology Course, Mar. 17-28, 1975 (attendance limited to 24 physicians), Raleigh E. Lingeman, M.D., David E. Brown, M.D., Ronald C. Hamaker, M.D., Robert H. Shellhamer, Ph.D., Garry L. Bolinger, M.D., course directors

Current Topics in Internal Medicine, Mar. 19-20, 1975, Richard N. Dexter, M.D., course director

Pulmonary Physician's Course, Mar. 24-28, 1975, co-sponsored by Indiana Chronic Respiratory Disease Control Program, Lewis W. Winter, M.D., course director

Care of the Burn Patient from Resuscitation to Skin Grafting, Mar. 26, 1975, Fort Wayne, Jack W. Patterson, M.D., course director

Disease of the Liver—Update 1975, Mar. 27, 1975, Richmond, Paul S. Rhoads, M.D., course director

Breast Carcinoma, Apr. 23, 1975, Gary, W. Glover, M.D., V. Hoftiezer, Ph.D., J. Vanden Berge, Ph.D., course directors

Chest Radiology, Apr. 23-25, 1975, Charles H. Helmen, M.D., Vernon A. Vix, M.D., course directors

Common Psychiatric Problems of Childhood and Adolescence, Apr. 30, 1975, Marian K. DeMyer, M.D., course director

6th Annual Emergency Care Symposium—Pediatrics, May 10, 1975, Lafayette, Lindley H. Wagner, M.D., course director

Current Concepts in Hypertension, May 14-15, 1975, co-sponsored by CIBA, Clarence E. Grim, M.D., Myron H. Weinberger, M.D., course directors

10th Annual Multidisciplinary Child Care Conference, May 14-15, 1975, Morris Green, M.D., course director

Geriatrics, May 28, 1975, Gary, Vincenzo DiCarlo, M.D., Aristotle N. Siakotos, Ph.D., course directors

Family Practice: A Review Course in Two Parts, June 10-12, July 8-10, 1975, co-sponsored by Indiana Academy of Family Physicians, A. Alan Fischer, M.D., course director

Cancer Symposia, conducted the second Wednesday of each month at Memorial Hospital in South Bend, Wallace S. Tirman, M.D., course director.

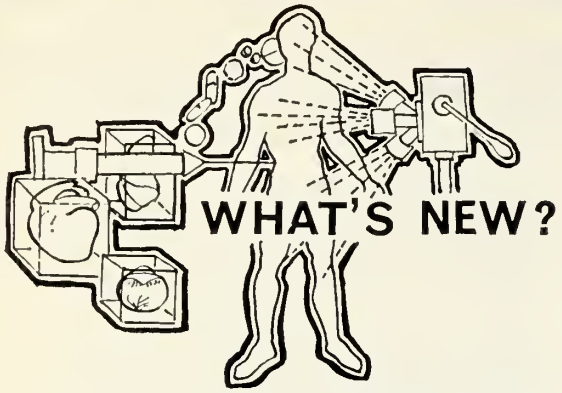
Kentucky Sets Endocrinology Course

The University of Kentucky Medical Center at Lexington will conduct a postgraduate course "Endocrinology for the Practicing Physician" on December 20-21. The registration fee is $75. Write Frank R. Lemon, M.D., College of Medicine, University of Kentucky, Lexington, Ky. 40506.

Gastroenterology Course Announced

A postgraduate course in gastroenterology will be conducted by the American College of Gastroenterology during a cruise aboard the S.S. Statendam from March 3 to 13, 1975. The ship departs from Ft. Lauderdale and stops at five ports on the northern coast of South America and in the Caribbean. For full details write the College at 299 Broadway, New York City 10007. ◄





Miles Laboratories is continuing distribution of its horizontal notation calendar for use by scientists. A single sheet, 34" x 23", contains a single line for each month, with a one-inch blank square under each date. Dates and locations of all significant scientific meetings are included. Calendars are obtained free of charge by writing Miles at Elkhart 46514.

* * *

Smith Kline & French has introduced "Anspor" (brand of Cephradine) a new broad spectrum oral cephalosporin. It is a companion product to "Ancef," an injectable cephalosporin, first marketed last year. "Anspor" is bactericidal, a property characteristic of all cephalosporins, because of its inhibition of cell-wall synthesis.

* * *

The Orthopedic Equipment Company of Bourbon has a new head halter for overhead cervical traction. It features patient comfort and ease of application. It is designated as the OEC "Upper 7" head halter. The company also announces an OEC Gagnon Splint for use in skeletal traction for fractures of the pelvis, femur or proximal tibia.

* * *

Herman Publishing announces a group of new books for health care personnel. It is called "The Essential Knowledge Series for Health Care Personnel." The series so far is composed of nine titles, each authored by a specialist in that field. The various books deal with anatomy, medicine, diagnostic tests, psychiatry, obstetrics, physiology, cardiology, biochemistry, endocrinology, nutrition and physics, chemistry and biology. Available in soft or hard binding.

* * *

Lemmon Pharmacal Company has a new Wright's Stain Speed Pak,™ which produces a uniformly stained, ready-to-read slide in less than one minute. Saturated pads of Wright's stain are packaged in foil, stored at 20 to 25 degrees C, and opened for use one at a time. The pad is placed on the slide for 30 seconds, and is immediately ready to examine after it is rinsed.

* * *

Endo Laboratories introduces MOBAN,® a chemically distinct antipsychotic, especially for the control of manifestations of schizophrenia. It rapidly aids arrest of symptoms while maintaining alertness. Tranquilization is achieved without muscle relaxing or incoordinating effects.

* * *

Behavioral Publications announces a new textbook "Teaching the Mentally Handicapped Child." It is edited by Dr. Ralph Hyatt and Norma Rolnick to provide a much needed theoretical and practical guide for those concerned with educating children with learning disabilities. 337 pages, $12.95 hardbound.

* * *

The 3M Company's Scrubteam soap-detergent-loaded scrub brushes for surgery are now sold with a double wrapping for greater protection. The brushes are made with either hexachlorophene or iodophor. A flexible backing allows the spongebrush to be bent for easier scrubbing of the skin surfaces between the fingers.

* * *

Because of the extreme comfort afforded, Orthopedic Equipment Company of Bourbon, Ind., is using Kodel® Polyester Pile in the manufacture of slings and restraints. Wrists and ankle restraints, and three sizes of traction slings, are included in the Kodel line.

* * *

Gale Research Press has a new dictionary. It is a supplement to the fourth edition of "Acronyms and Initialisms Dictionary." Titled "New Acronyms and Initialisms — 1974" it lists over 12,000 newly coined and newly found terms. The fourth edition, which the new publication complements, contains nearly 103,000 entries.

* * *

Space Sciences has a new battery-operated electronic stethoscope. It extends the hearing range by several orders of magnitude. More accurate evaluations of pulmonary, cardiac and obstetrical sounds are possible. Amplification is controllable over a wide range.

* * *

Armstrong Industries announces availability of the new "MAST-1 Anti-Shock Trouser," a device for applying external air pressure to the lower extremities and lower abdomen to provide an "autotransfusion" and maintain the circulating blood in the thorax and head. It is indicated especially in trauma-induced hypotension or hypovolemia from any cause.

* * *

Orthopedic Equipment Company has taken notice of the difficulty in obtaining pearl buttons for anchoring abdominal wound retention sutures. They make nylon buttons which are packaged sterile in a peel-back package together with one bolster.

* * *

J. J. Keller & Associates announces publication of the "Metric Manual," containing all essential metric data relative to conversion to the metric system. It is published in loose-leaf, 3-ring-binder format. Copies are available at a special introductory price.

* * *

News of what is new in the medical supply industry is composed of abstracts fram news releases by manufacturers—of pharmaceuticals, clinical loborotory supplies, instruments and surgical appliances—and book publishers. Each item is published as news and does not necessarily constitute an endorsement of a product or recommendation for its use by THE JOURNAL or by the Indiana State Medical Association.

Association News

BOARD OF TRUSTEES

August 24, 1974

The meeting of the Board of Trustees of the Indiana State Medical Association was called to order at 8:30 a.m., Sat., Aug. 24, at the Inn of the Fourwinds, Lake Monroe, Smithville, with Vincent J. Santare, M.D., chairman presiding.

Roll call showed the following:

Dist.	Trustee	
1	Bernard B. Rosenblatt	Present
2	Paul W. Holtzman	Present
3	Eli Goodman	Present
4	Howard C. Jackson	Present
5	Cleon M. Schauwecker	Present
6	Paul M. Inlow	Present
7	John O. Butler	Present
7	Joseph F. Ferrara	Present
8	Richard G. Ingram	Present
9	William M. Sholty	Present
10	Vincent J. Santare	Present
11	James A. Harshman	Present
12	John S. Farquhar, Jr.	Present
13	G. Beach Gattman	Present

Dist.	Alternate	
1	E. DeVerre Gourieux	Absent
2	Betty Dukes	Absent
3	Thomas Neathamer	Present
4	William F. Blaisdell	Absent
5	William G. Bannon	Absent
6	Glen Ward Lee	Present
7	Donald C. McCallum	Absent
7	John G. Pantzer	Absent
8	Jack L. Alexander	Absent
9	Max N. Hoffman	Absent
10	Martin J. O'Neill	Present
11	Lloyd L. Hill	Absent
12	Walter D. Griest	Absent
13	Donald S. Chamberlain	Absent

Officers and Executive Committee

Joe Dukes	Present
Gilbert M. Wilhelmus	Present
Hugh K. Thatcher, Jr.	Present
Arvine G. Popplewell	Present
Frank B. Ramsey	Present
James H. Gosman	Absent
John W. Beeler	Absent
William E. Cast	Absent
Donald M. Kerr	Present
William R. Clark	Present

ISMA Staff

Robert J. Amick	Present
Kenneth W. Bush	Present
Howard Grindstaff	Present
Michael McDermott	Present
James A. Waggener	Present

Delegates/Alternates to AMA

Lowell H. Steen	Present
Thomas C. Tyrrell	Present
Peter R. Petrich	Present

AMA Field Secretary

Al Lerner	Present

APPROVAL OF MINUTES

Chairman Santare: Dr. Ferrara has moved, Dr. Harshman has seconded, that the minutes be approved as published. All in favor? Opposed? Carried.

REPORT OF EXECUTIVE COMMITTEE CHAIRMAN:

Payroll Changeover

Doctor Kerr: The Executive Committee met last night on about 57 items, the following of which we are referring to the Board for action. The first matter was our office payroll. The bank has been doing this. They have just announced they are going to increase the fees for so doing, and Jim and our accountant-bookkeeper lady have concluded they can do it with available staff at a savings of $500. The Executive Committee suggests that this is a good way to go.

Doctor Goodman: I so move.

The motion was seconded and carried.

Data Processing Group

Dr. Kerr: We have a recommendation that we change from the present data processing group and use the AMA computer. Mr. Waggener will enlarge on that.

Mr. Waggener: The AMA has been experimenting for about a year and a half, or two years, on offering to state societies a computer system on membership. It is essentially the same as we have been using now. We are paying a $1.50 fee per member per year for the data systems. The AMA will do it for $1.20, although they will charge us for some services which Data Control has been granting us for nothing. In analyzing the usage of labels and address lists, and so forth and so on, there will be probably $100 less in savings per year on a change-over. We do believe that the AMA system is a little bit more flexible than what we have now. They will guarantee us a makeup within 48 hours of receiving the materials and will enable us to break our list down by specialty societies and otherwise, and we would recommend the change because it ties right in with the AMA membership records which are done from ours anyway.

Doctor Thatcher: I move that it be done.

Doctor Sholty seconded. The motion carried.

Tel-Med

Doctor Kerr: The next item we discussed was Tel-Med. It has been a very popular program but we are finding that it is getting increasingly expensive and we are going to have to figure out other ways of financing it. The estimated yearly cost for the program as now established is $99,182.61. We had money from Lilly and RMP but we are going to run out of this. It is our hope to get some other pharmaceutical houses involved. I don't know any specific action you need take at this point except a lot of thinking. And we have to decide whether that program is worth it and what it is going to cost. We figured it out about $20 a member approximately, $20.92 per member. We will pursue other pharmaceutical houses and voluntary health agencies, but you better figure on something in your dues structure if you are going to have this for an ongoing program. It is unlikely they will year after year keep on donating to Tel-Med. Mr. Waggener points out that RMP did give us $64,000 for this program. It is anticipated that after July 1 we should not count on that because RMP itself will probably not be funded.

Chairman Santare: Is there a motion or recommendation that we have our president appoint a subcommittee to investigate the various modes of obtaining funds for Tel-Med?

The motion was made, seconded and passed. Dr. Dukes named Dr. Farquhar as chairman and Dr. Inlow and Dr. Sholty to the committee.

Architects' Report

Doctor Kerr: The next thing that we did discuss was the report of the architects on the building program. Dr. Thatcher, do you want to make a comment on that?

Doctor Thatcher: We have the following information back from the architects —a large scheme and a small scheme. The large scheme is approximately 16,000 square feet of floor space; the small scheme approximately 10,000 square feet of floor space. Lennox, Mathews, Simmons and Ford are the architects. They came back with the following figures: For the large scheme, it would cost us approximately $510,939 or $28.47 a square foot. The small scheme would be $407,216 or $32.76 per square foot. Approximately $10,000 in each instance could be deleted from this amount in the event that we did not tear down the residences back on Pennsylvania Street. There was an estimate given that by next spring, building costs would be up approximately 20%, so you are talking about something like an additional $100,000 on that. We feel that it is possible to obtain some space at the present time if the CHAMPUS program was moved out to one of the two adjacent houses. Uncle Sam pays the rent on that anyway; it would not be any money out of our pocket. We could, when our leases run out, take over the two houses behind us, utilize space back there, and clear out some space in our basement which we are now using for storage. However, it is the recommendation of your building committee as referred to the Executive Committee and it is referred to you as

a judicial body in this particular instance, and that we take these figures to the House of Delegates so as to let them make the decision in regard to any matter that involves this much money.

There was lengthy discussion by the Board on the building expansion.

Doctor Goodman: Mr. Chairman, I would move that this be referred to the House with a yes-endorsement by the Board. House to choose between the two.

The motion was seconded and passed.

Malpractice Survey

Doctor Kerr. The next item was that of malpractice survey. As you know, the Commission on Medical Economics and Insurance has been instructed to proceed with the investigation of the establishment of our own insurance company. We have met with gentlemen from Florida and discussed a survey—a response which was not overwhelming. One would have thought we would have had a great response since so many people seemed to be concerned about the availability of coverage. There is a large volume of material which you can't possibly consume this rapidly for action other than to permit the Executive Committee to make the recommendation to the Commission on Insurance to proceed with their study of it and hopefully to have a concrete proposal of costs, benefits and definite plans available for consideration by the House in October.

Doctor Wilhelmus: I would like to make a statement about this survey. Gentlemen, if you look at this form, it has me worried. It has the doctor's name, insurance or not, and how much he has. I would not want my name on it; this is dangerous to pass out, gentlemen.

Doctor Kerr: As you will recall, there was considerable objection to the card when it went out. This may have something to do with the fact that we didn't get a higher response than 33%. At least from all indications the matter of medical liability insurance is going to be a continually more difficult one. At any rate, we would ask that the commission be instructed to go ahead and pursue the program.

Chairman Santare: The motion has been made and seconded that this Board inform the Commission to proceed on this particular program.

The motion passed.

Letter from Orange County

Doctor Kerr: The next item was a letter from the president of the Orange County Medical Society to the Board of Trustees. I will read it to you. "The Orange County Medical Society requests the assistance of the Board of Trustees in resolving a problem of relationship with Dr. Ray Murray and the Department of Community Health Sciences at Indiana University Medical Center. We were contacted by Dr. Murrays' assistant, Dr. Jack Hardigg, in March, 1974, and asked our participation in a health services survey of its citizens. We were given a sample copy and after consideration of the proposed questionnaire, we determined all of the desired information was already of record to the State Board of Health reports, local hospital analysis, local school records, etc., and felt that we would rather the survey not be done. This we informed Dr. Hardigg and assumed our wishes would be accepted. On return from a vacation in mid-June, I found a letter from Dr. Murray telling us they were going ahead with the survey regardless of the County Medical Society desires. Since then, we have become aware that there are surveyors here in the county calling on private citizens and asking answers to the questionnaire that we rejected. The Orange County Medical Society feels that inasmuch as we are responsible for the medical care of our community, outside paramedical organizations should work only through us or be totally discouraged. And in this light we respectfully request the ISMA provide us with the appropriate support."

It was moved by Dr. Goodman, seconded by Dr. Jackson, that the Board deplore the solicitation of medical-based data without the collaboration and approval of the county medical society and the Indiana State Medical Association. The motion passed.

Chairman Santare: Now, Dr. Dukes, you would like to have a two-member liaison committee with ISMA School of Medicine meet with Dr. Murray and Dr. Beering.

Doctors Dukes, Gosman, Santare, and Wilhelmus were named to meet with Drs. Murray and Beering.

Chairman Santare: Dr. Dukes, will you put that in a form of a motion that this committee meet with Dr. Beering and Dr. Murray?

The motion was made, seconded and passed. It was also moved and passed that a report be made to the Board at the next meeting.

Chairman Santare: Is there a motion that we establish policy that our members be asked not to cooperate with a survey unless it has been presented and approved by the Board and the Board has access to the statistics from the survey? Motion was made by Dr. Goodman and seconded by Dr. Jackson that the Board establish a policy that our members not participate in surveys unless the survey has been submitted to the local or state organization for approval and that the statistics received as a result of the survey be made available to the particular organization, state or county. Dr. Goodman called for the question.

The motion passed.

Doctor Holtzman. There is a little bit more to this than any of you men may know. There is an organization called IMPERG that comes out of Indiana University and it is not connected with the medical school but is connected with the business school. This is a consumer group and they are the same group that attacked Maryland if you remember. They have attacked the Indiana pharmacists. This is funded by Miller in Columbus, among other things. They started with the Bloomington doctors about three months ago and they had a long list of questions that they wanted to know: Your cost per year, do you make house calls, what is your minimum office charge, what is your maximum office charge, do you accept new patients, will you make night calls, etc.—three pages of questions. Fifty of the 117 doctors responded and then we started getting the telephone calls as to why hadn't we answered their questionnaire. And then for those of us who did not answer the questionnaire, they sent a brochure saying that they would put in their report that this doctor refused to cooperate. And then the next step was that they called the office receptionist and got the information from the receptionist. We threatened them with legal action, much as was done in Maryland. Then we asked them what their board would do and they indicated they were not concerned. This is controlled through Indiana University and I suggest it might be a better approach here to inform actually the president of Indiana University rather than the dean of the medical school—let him know what is going on.

Doctor Farquhar: I believe that you need to take action in these cases but attempting to restrict the right to inquiry is not the action that is going to do you any good. I would move that ISMA voice an official protest to the J. Irwin Miller Foundation concerning IMPERG—and on their allegations about physicians who do not fill out their questionnaire.

The motion was seconded.

Chairman Santare: Question is that we address a letter to the Foundation.

Doctor Farquhar: This particular survey is offensive and it tends to defame the physician who does not answer it. I think that the objection should be made to the Foundation—that the Foundation's funds may not be spent toward these objectives.

Chairman Santare: John, will you accept the amendment to the motion?

Doctor Farquhar: Yes, I would accept my motion amended that a second protest be sent to the pesident of Indiana University that IMPERG is representing itself as an official agency of the uni-

versity and it is charging the fee which is misrepresented as an academic fee.

The motion passed.

Privileged Information

Doctor Kerr: The next item deals with a so-called privileged information and violations relative to third parties. We have asked an opinion from our attorneys: Stewart, Irwin, Gilliom, Fuller and Meyer.

The opinion was read by Dr. Kerr, which reads in part: "There is no Indiana statute which specifies that hospital records per se are confidential since most hospital records are composed of physician statements. Based on their examination or conversation with the patient, such records would be confidential to that extent unless expressly or impliedly waived by the patient. Obviously the most common form of expressed waiver is some document signed by the patient authorizing the bearer of the document to examine hospital records of the patient."

Doctor Harshman: I made a statement at the last Board meeting. I thought there was a clause in the participating contract that required hospitals to divulge materials to the Blues upon request from them. I have had occasion to go over the participating contract of our hospital and there is not a single word in the contract that says our hospital has to supply them with any medical records material.

Chairman Santare: This is exactly what Dr. Dukes is saying—that in regular business this is not so, but as far as Medicare and Medicaid are concerned, Mutual Medical Incorporated gets authorization to obtain all information, both medical and nonmedical. But this again is not a participating contract between hospitals and the intermediary. This is the hospital asking specific permission from the patient to release records, and again this would be records concerning fiscal matters and confidentiality.

Doctor Popplewell: One of the things the hospitals do when the patient is admitted—they sign some kind of statement obligating them to be responsible for the hospital bill. A part of the wording in the statement they sign provides permission for the institution to provide a third-party carrier with any information necessary in order to collect the bill.

It was moved that the matter be turned back to the Executive Committee to take to the IHA. It was seconded and passed.

ISMA Insurance with Blue Cross and Blue Shield

Doctor Kerr: The next item is a matter relating to ISMA's insurance with Blue Shield/Blue Cross, our own state program. One of our members has had considerable difficulty with it—particularly the major medical program. I am going to read the letter to you.

The letter read in part: "As we have explained in our several telephone conversations, we do not receive these bills because of professional courtesy and the medical ethics involved. We, therefore, cannot collect and present to you in the usual manner. Since this policy was written for Indiana State Medical Association physicians, it would seem that there should be some procedure change in Blue Cross/Blue Shield processing of these claims and the payment of them. In other words, why can't Blue Cross/Blue Shield pay the provider directly as claims are received?"

Doctor Santare: I will pass this on to our Board Committee. I would like them to have a copy of this and will ask if these people can be stimulated so as to have a better processing of claims for ISMA policy. We will now proceed with Dr. Dukes' report.

PRESIDENT'S REPORT

Doctor Dukes reported that the West Virginia State Medical Association intends to work toward amendment or repeal of PSRO. They resolved that their Constitution and Bylaws be amended that all members shall be members of the AMA and resolved that the standard claim form for physicians and patients be adopted.

Doctor Dukes: Here is one I liked. The physicians of the State of Virginia in rendering service to welfare recipients, crippled children, division of vocational rehabilitation and others, where they have not received their usual and customary fees and accept these curtailed fees, subsidize paid agencies. The delegation of West Virginia was instructed to introduce a resolution to the AMA for income tax credit for these contributions. As I understand, Congressman Corman from California introduced a bill that a physician who takes assignments on these federal programs would be provided with malpractice insurance. I also learned from the ophthalmologists out there that the HEW is going to assign unidentified secret people who will review the peer reviewers.

Doctor Santare: Dr. Wilhelmus, our president-elect, will report.

REPORT OF PRESIDENT-ELECT

Doctor Wilhelmus: The more I become involved in this organization and the more I go to the AMA meetings as an officer, the more I am impressed with our AMA delegation—Drs. Harshman, Steen, Scamahorn, Corcoran, Senseny—they are our regular delegates. These gentlemen work; they have a good time, yes, but they work. They know what is going on; they know a lot of people and they do their very best for medicine in Indiana. I personally would like to congratulate them.

I have set up three trips abroad for next year for our Association. February 21 we will have an African trip. The last two weeks of May will be a trip to Brussels and a trip down the Rhine. The last two weeks in October will be a trip to the Holy Land.

At the last meeting I suggested that Doctor Lucas of Blue Shield be invited to our next Board meeting. Since he is not here I still would like to urge us to invite Mr. Lucas.

Doctor Santare: I think Gilbert's idea was to just have him become acquainted with some of our ideas concerning utilization review. If there are no questions of Dr. Wilhelmus we will proceed with the report of our treasurer, Dr. Thatcher.

Doctor Thatcher made a lengthy detailed report on ISMA's financial condition.

REQUEST OF COMMISSION ON MEDICAL EDUCATION AND LICENSURE

Doctor Harshman: How much money is the Commission on Medical Education and Licensure asking for?

Doctor Santare: $500 for a booth at the state convention. The Executive Committee determined that we would give them a booth but we couldn't give them any money since they were so far overbudgeted.

Doctor Dukes: Does anybody know what they plan to do?

Mr. Waggener: They are planning on putting on an exhibit on the Continuing Medical Education program.

Chairman Santare: Dr. Dukes has moved that the Board make a decision as to whether the $500 should be given or not.

Motion was seconded.

Chairman Santare: Any further discussion? Motion was voted upon and carried that the $500 go to booth expenses for the Committee on Continuing Medical Education.

Doctor Ingram: I move that we review the material they intend to put in their booth before it is actually put on the floor.

Doctor Santare: Motion has been made that this be reviewed and it has been seconded. Is there any discussion?

Doctor Ingram: Quite frankly, we have had some material from this Commission. I realize that they are a hard-working group—everybody has made that point. I realize too, but certainly not always, has the Board agreed with the material that has come from this Commission; and we have, in fact, at

times reversed their decision. To give them permission to make a public presentation at the state convention without looking at it, I think, is probably a serious mistake.

Chairman Santare: I think what Dr. Ingram is requesting is reasonable. The suggestion is made with the motion that the commission make a short resume on what is to be presented and send it to the Board.

Motion was seconded and carried. Dr. Santare then called on Dr. Ramsey, JOURNAL editor.

REPORT FROM THE JOURNAL

Doctor Ramsey: I think I am getting a little more expert with deficit financing here and I am going to get to the deficit budget a little bit more closely than I was last year. I am pretty sure we are not going to go over that budget, particularly proud of the fact that while our national advertising has decreased as it has for everybody (There are state journals actually going out of business now.), our direct advertising, that we sell ourselves, so to speak, here in Indiana, is bigger. Also, a sale of reprints is above what was expected to be and in general, except for national advertising, I think THE JOURNAL has been running along pretty well lately this year. I am embarrassed by having more scientific informational material than possibly can be published due to the budget. The issues have been smaller but we've tried to put in the most important and the most interesting things and try to condense what we do have into smaller space, as is possible. The one thing we can't do anything about, of course, is inflation, like everything else. If you set a price on paper that you are not going above, you just end up not getting any paper at all.

Doctor Ramsey reported much additional detail about the JOURNAL operation.

REPORT OF THE AMA FIELD SECRETARY.

Mr. Lerner: I just have two quick items I want to report to you; they both concern legislation. One is the present status of the House Planning Bill 16204 and the other one is our old friend, national health insurance. Last Thursday, the House Congress Committee failed to get a quorum before they adjourned on 16204. Therefore, they are adjourned until after recess. I think what this means is it gives us all time, the AMA and the states, to develop some type of comprehensive strategy to deal with 16204 Committee. The AMA Legislative Department now is in the process of developing an in-depth analysis of the bill, which should be mailed out to the states on Monday. The bill creates a highly structured planning resource development and regulatory program—all interdependent with heavy centralized authority on the Secretary of HEW. It has certification procedures with planning and development functions and creates new controls over the health field. Mr. Lerner then explained in detail the bill's composition.

Doctor Goodman: Mr. Chairman, I move that a five-man committee on national health insurance be formed.

It was then suggested as part of the agenda formation, the Board have a recap at each Board meeting by this committee, organized in advance, so that the Board can concisely in one unit of time understand what is happening since the last meeting.

Doctor Goodman: I suggest they summarize these various things so that at our Board meetings, or in between as needed, Board members may be given copies.

Chairman Santare: I will also add that the trustees submit names of people to be on this committee and that at our next meeting we will see who has been submitted rather than have Dr. Dukes and myself select the committee. I would rather the committee be the expression of the Board rather than any particular individual.

Motion to form the committee passed. On Sunday, August 25, Doctor Santare named to the committee: Dr. Wilhelmus, chairman; and Doctors Goodman, Ingram, Gosman, Dukes, and himself.

Doctor Holtzman: I would still like to have all the members of Roger's committee, because I don't think we need necessarily direct our correspondence only to Indiana's congressmen.

Mr. Waggener: When I get the analysis, I'll send it to all of you.

DISTRICT REPORTS:

Doctor Goodman: The Third District Annual Meeting will be a joint meeting with the District Academy of Family Practice on September 14 and 15 at the Marriott Inn in Clarksville. This is a weekend arrangement and a delightful place.

Chairman Santare: Tenth District. I have a public announcement to make. The Tenth District has set up a meeting but because of improper arrangements, they changed the date to Sept. 25. They found out Sept. 25 at sundown starts Yom Kippur. We apologize for this error, and they say that they will conduct all the business and elections in the early part of the afternoon if anyone wishes to leave by sundown—at least they will have participated in the business part of the meeting.

Doctor Harshman: Eleventh District is meeting at the Holiday Inn, Logansport, Sept. 18. I have one letter for remission of dues because of ill health, and I so move.

Chairman Santare: Motion is made and seconded that this member be granted dues remission because of ill health. The motion passed.

Doctor Farquhar: The Twelfth District annual meeting is on Wednesday night, Sept. 19, in Fort Wayne at the Marriott. The Governor will be the featured speaker, also Dr. Beering, dean of the medical school, will be there. You are all most cordially invited.

Doctor Gattman: The Thirteenth District meeting will be on Sept. 11 at the Elcona Country Club.

BOARD LIAISON COMMITTEE WITH BLUE CROSS:

Doctor Harshman: We have met a couple of times with Blue Cross since our last board meeting. I think one item we should mention to you is the outpatient program which is experimental in six counties—Howard, Grant, Monroe, Vigo, Tippecanoe, and one other county—a program whereby they reimburse you for supplies to do surgery in physicians' offices.

Chairman Santare: Jim, aren't they looking into some of the other things? We have a cardiac catherization lab in a clinic. They are looking into paying for the cost in the clinic since it seems to be a much cheaper level than is being done in the hospital.

Doctor Harshman: They are very interested in entering into experimental programs dealing with different methods of delivery. I think it is a forward thing on their part to explore the various avenues in health delivery.

BOARD LIAISON COMMITTEE WITH I.U. SCHOOL OF MEDICINE:

Doctor Wilhelmus: The committee did meet with the dean this past six weeks. We discussed many items in AMA area, autopsies, etc. The dean said they had an over-supply of bodies at I.U. School of Medicine, and he suggested one thing, and we have discussed this when Doctor Petrich was chairman, and is still chairman of the membership committee. The Dean is very anxious to have more of his faculty belonging to ISMA. He has reviewed the salary structure at I.U. School of Medicine and on a full-time professorship does not think they are getting paid sufficiently to pay the entire dues structure we have—a local society, the ISMA, and the AMA. We would like to see the membership committee come up with a suggestion for special membership for the I.U. School of Medicine faculty—the full-time faculty. Mr. Chairman, I would like to move that we refer this to the membership committee.

The motion received a second and passed with the stipulation that the com-

mittee's report be given to the Board for further action.

BOARD LIAISON COMMITTEE WITH BLUE SHIELD

Chairman Santare: Dr. Holtzman, the Chair will remind you that you have the matter of Dr. Cohen's letter and that you do have a member of your committee, Dr. Gattman, who is on the Board of Directors of Blue Shield, to see if this committee can expedite an explanation of processing of claims for our ISMA policy. Also that there are three nominations to come from the Board of Trustees for at-large members on the Blue Shield Board of Directors. The present incumbents are: Dr. Gutierrez of Crown Point, Dr. McIntosh of Riley, and Dr. Glock of Fort Wayne. We would like your committee to come up with some recommendations for the next Board meeting.

NEW BUSINESS

Doctor Goodman: I believe that it is appropriate under new business to bring to the attention of the Board a report we have gotten from our state headquarters—a report from the Department of Defense—which I thought was a very excellent report on the functioning of our headquarters in the matter of CHAMPUS. I would move that this Board commend the headquarters staff. The motion was seconded and passed.

PSRO SUPPORT CENTER

Chairman Santare: If you will note on tomorrow's agenda, I asked Dr. McIntosh to be present and this matter was brought up at the last Board meeting. The question of a PSRO support center arose and was turned down by this Board for us to apply for it as a not-for-profit organization. An application was made by Dr. McIntosh. He had talked to members of the Board and the Executive Committee and the officers concerning being members of this Board prior to the Board's rejection of this particular proposal. It was submitted despite the Board's rejection. I did meet with Dr. McIntosh in Chicago at the AMA convention and I looked at it. There was one name submitting it—it was Dr. McIntosh.

I asked him who was on it, the board, and he had no people on his board but he intended to ask Dr. Dukes, Dr. Wilhelmus, Dr. Farquhar, Dr. Clark, myself, Dr. Petrich and Dr. Butler. As far as I knew that particular time, there was no organized board; there were no individuals in that particular group. A proposal was submitted and it was funded for $192,000. So we now have a PSRO-support center in the state of Indiana in which there is a project officer, Dr. McIntosh. He has hired an office which is in Park Fletcher, and has hired a Mr. Hudson as the executive director, who formerly was employed with the Indiana State Board of Health. I bring this up as a matter of information.

Doctor Harshman: I think this Board should submit to the Support Center a bill for about $1,000 for figuring out their budget for them. I think Mr. Waggener has spent a considerable amount of time figuring out the budget for us, and the Board turned it down. I think they have taken those figures and turned them in to HEW and they got $192,000. Jim had quite a bit of time in on it, a lot of leg work, and I think he should be well compensated for it.

Doctor Ingram: I think we would indicate a conflict with our policy if we ask them for the $1,000 but when we have a member of our Board of Trustees sitting on that board, I think that is also conflict of interest. That, frankly, upsets me. With all due respect, I know Dr. Butler feels differently about this than I do. However, he is a member and an elected member of this Board. It has been my distasteful job, sometimes, to carry out policies that I oppose because of mandates of the House of Delegates. That being the case, I think it might have been good judgment had he not joined this group.

Doctor Ingram: I would like a clear verification of policy and duties of a trustee. Is it true, then, that I may follow the opinions of my district independently, joining whatever organizations, taking whatever action I wish, even when it is contrary to the stated policy of the House of Delegates of the State Medical Association? I'd like to know that. I think that is an important question, very important.

Chairman Santare: I think it is a touchy problem. I can tell you what my working policy is on that. I think as a functioning member of ISMA, and as a member of the county medical society, too . . . I think in the past when ISMA has passed a policy, it has been always allowed the county medical societies their individual action on such matters as peer review, etc.

Doctor Ingram: But is it possible, then, for me to divorce myself? In other words, I am in the eyes of the doctors of Indiana a trustee of the State Medical Association, regardless of whether I am working in my office, attending a meeting in Anderson, or Muncie or one in Indianapolis.

Doctor Schauwecker: I am very embarrassed about this thing because this is part of Sixth District and at our last Sixth District meeting, most of the business portion was on PSRO and everybody there from Vigo County was saying in effect that if the AMA did not fight the repeal of the PSRO, they were going to drop out of the AMA.

Doctor Goodman: There seems to be a possible conflict of interest. I would like to suggest that we all study our Constitution and Bylaws, sections on duties of trustees; and I'll put that in a form of a motion if you wish.

Chairman Santare: Dr. Goodman is moving that we look over our Constitution and Bylaws this evening and that this be brought up tomorrow.

The motion was seconded and passed.

REPORT ON I-MEDIC

Doctor Petrich: As you recall, at our meeting on the previous occasion relative to the organization of the mandated corporate structure for peer review, I proposed a set of articles of incorporation and bylaws. Rightfully, as not many of you had had an opportunity to see them, some discussion took place of a minimal nature at the time; and it was proposed that you send to me any and all suggestions that you might have relative to those articles.

Doctor Petrich then reviewed the recommended changes in the corporation's constitution and bylaws.

Doctor Harshman: I move that we accept the articles of incorporation.

Doctor Gattman seconded the motion. Amendments were then offered by members of the Board.

Doctor Ingram: I have another amendment that I would like to add. I would like a word added at the end of that section (F), though, "again only by permission of local reviewing body." I feel that it is necessary to repeat that statement in that segment even though it is stated before in part B. I just don't think we can say that often enough. I would like those words added.

Doctor Ingram made a motion to this effect and it was seconded. Considerable discussion followed. The motion to add the phraseology to Section F passed by a vote of 8 to 6.

Chairman Santare: We have the amendment approved. Now the motion is to submit these articles of incorporation to the attorney as amended.

The motion passed.

The Board recessed until 8:30 a.m., Sunday, Aug. 25, 1974.

BOARD OF TRUSTEES

August 25, 1974

The meeting of the Board of Trustees reconvened at 8:55 a.m., Sunday, Aug. 25, 1974, at the Inn of the Fourwinds, Lake Monroe, Smithville, with Vincent J. Santare, M.D., chairman presiding.

Roll call showed the following:

Dist.	Trustee	
1	Bernard B. Rosenblatt	Present
2	Paul W. Holtzman	Present
3	Eli Goodman	Present
4	Howard C. Jackson	Present
5	Cleon M. Schauwecker	Present
6	Paul M. Inlow	Present
7	John O. Butler	Present
7	Joseph F. Ferrara	Present
8	Richard G. Ingram	Present
9	William M. Sholty	Present
10	Vincent J. Santare	Present
11	James A. Harshman	Present
12	John S. Farquhar, Jr.	Present
13	G. Beach Gattman	Present

Dist.	Alternate	
1	E. DeVerre Gourieux	Absent
2	Betty Dukes	Absent
3	Thomas Neathamer	Present
4	William F. Blaisdell	Present
5	William G. Bannon	Present
6	Glen Ward Lee	Present
7	Donald C. McCallum	Absent
7	John G. Pantzer	Absent
8	Jack L. Alexander	Absent
9	Max N. Hoffman	Absent
10	Martin J. O'Neill	Present
11	Lloyd L. Hill	Absent
12	Walter D. Griest	Absent
13	Donald S. Chamberlain	Absent

Officers and Executive Committee	
Joe Dukes	Present
Gilbert M. Wilhelmus	Present
Hugh K. Thatcher, Jr.	Present
Arvine G. Popplewell	Present
Frank B. Ramsey	Absent
James H. Gosman	Present
John W. Beeler	Absent
William E. Cast	Absent
Donald M. Kerr	Present
William R. Clark	Present

ISMA Staff	
Robert J. Amick	Present
Kenneth W. Bush	Present
Howard Grindstaff	Present
Michael McDermott	Present
James A. Waggener	Present

AMA Delegates/Alternates	
Malcolm O. Scamahorn	Present
Patrick J. V. Corcoran	Present
Lowell H. Steen	Present
Ross L. Egger	Present
Thomas C. Tyrrell	Present
James A. Harshman	Present

Guest	
Wilbert McIntosh	Present

REPORT FROM THE AMA DELEGATES

Chairman Santare: Dr. Steen has been delegated this morning to give the opening remarks of the AMA delegation.

Doctor Steen: Gentlemen, as you know, at the recent meeting of the American Medical Association House of Delegates there was a stormy session. There were some 150 resolutions, approximately 50 Board and Council reports. Something near and dear to Indiana hearts, PSRO, had two reports—one from the Council on Medical Service and one from the Board of Trustees, and some 25-odd resolutions. An excellent presentation of Indiana's views and what had happened in Indiana with reference to PSRO was presented by Dr. Scamahorn by unanimous consent of our delegation. He did an outstanding job. Dr. Blaisdell then spoke to the issue as an individual. Dr. Crane from Bloomington then spoke as an individual. But, as you know, in the long run, when the issue came to the floor for the vote, skillful parliamentary maneuvering had occurred. Dr. William Hildebrand, the chairman of the Council on Medical Service, came to the microphone very early in the game and stood there for approximately 30 minutes. He was recognized, moved to terminate the debate and to vote immediately. The thing carried by an overwhelming majority. There were 50 votes against the AMA position. They asked for a standing vote. We looked like we were dead trees in a forest. And as you know, we were not successful in re-electing Dr. Wood. We worked very hard at this, but the night before the balloting, most of the delegates were there, and at that particular time we thought we had enough votes to elect him on the first ballot.

Doctor Goodman: Mr. Chairman, I would like to move that this Board, through its chairman and officer group, send the appropriate communication to Dr. Wood, thanking him for all that he has done for organized medicine and for the state of Indiana in particular—also some appropriate sentiment about his not being re-elected.

The motion received a second and passed.

PSRO SUPPORT CENTER

Doctor McIntosh: I think I should review this from the very start. First, I think I should tell you the philosophy of the people who met first and who have been meeting since. Their philosophy was, at the time, that PSRO probably was inevitable and they should do something for the physicians and for the patients of Indiana with the knowledge of organized medicine but not for the organized medicine to be associated with us. In other words, someone had to do it and still work with the Indiana State Medical Association. This has been brought out at every meeting. It has been everyone's knowledge and this is why the people who were in it were selected because of their relations with the ISMA, not as Indiana State Medical officers but as Dr. John Doe out in his community. Now, I thought we should understand our thinking, whether it was right or wrong.

Doctor McIntosh explained in detail all of the events, dates of meetings, individuals involved, and current status of the PSRO Support Center. He reported that the Center will receive $196,000 to start with and that nine members are planned for the Board—one physician from each of the planned PSRO districts, a doctor of osteopathy, and an at-large member. Following his presentation he was questioned extensively by the Board.

Doctor Thatcher: Dr. McIntosh, one thing I would like to ask you and have go on the record: In the event that the House of Delegates should re-align itself and mandate the Board to pick up the Foundation concept and take over the support center, would you be willing to waive and let them take it over?

Doctor McIntosh: This would be the organization's vote; it wouldn't be up to me. Personally, sure.

RECONSIDERATION OF I-MEDIC

Doctor Goodman: Mr. Chairman, in the last few minutes I heard from my colleague, Dr. Ingram, reference to the spirit of the House of Delegates. I would like to recall historically the last year or two of PSRO being a prime issue as it is being this morning. And, in my opinion it was the spirit of the House of Delegates at its last meeting that we as a state group opposed PSRO as a mechanism for the good of the people of the state of Indiana and for the physicians of Indiana. It is further my opinion that, in due deliberation, the House last fall directed this body to proceed with the development of an alternative, a statewide PRO, which we could control and which would be free of governmental domination. This Board, in its wisdom chose to ask Dr. Peter Petrich to prepare such a program. He presented that alternative to this Board yesterday morning. I ask this Board this morning, in its wisdom, to reconsider the amendment offered by Dr. Ingram yesterday.

Chairman Santare: Motion is made for reconsideration.

The motion was seconded and passed.

Chairman Santare: Your motion, Dr. Goodman, is to delete the amendment?

The motion to delete the amendment was seconded, and the motion passed.

Doctor Schauwecker: I would like to go on record. Doctor McIntosh is a member of our district; and I have absolutely nothing but admiration for somebody, who, while he knows it is an unpopular topic, and while he knows he is sticking his neck out a mile and a half, will yet go ahead and do it. This is not to say that I agree with this procedure, or that I, personally, would have done it. I still

believe that PSRO is very bad, but we are living in a fairyland if we think that some sort of national health insurance is not coming, that PSRO is not here; and we must try to control it.

Doctor Ingram: Well, everyone is putting statements of philosophy on tape so I have one that I would like to give you. I think it is interesting the mental manipulations that we're able to go through to defend our own personal position. I think that has happened this morning. I'm a little disappointed. This is number one. Number two, I think the day will come, and very soon, when every man on this Board will regret the action he has taken this morning. I think there is a very large mistake. I've heard the rhetoric. We must do it to ourselves before they do it to us. I have heard people be sorry about it before, and I feel quite confident that once again we will be sorry about it.

REPORT OF BOARD COMMITTEE ON ECONOMIC AND FISCAL MATTERS

Doctor Goodman: Mr. Chairman, your Board Committee on Economic and Fiscal Matters met yesterday afternoon at the conclusion of the general session of the Board and came up with, I suppose, some unpleasant conclusions, which I will report on very briefly. I might preface my report with the statement that it seems some several years ago that this authority requested that all resolutions be accompanied by a fiscal note—at least those requiring expenditures of funds. In the last two or three years we have approved up to some half-dozen programs that are going to require the expenditure of sums of money—some of them very large, such as our Tel-Med, about which we have discussed finances, the speakers' program, for which we have allocated a rather large amount of money (most of which has been lying rather dormant). This morning we authorized the development of a non-profit corporation called I-Medic which is, of course, going to require funds. For the bulk of these we really have no fiscal note of any kind. Therefore, your committee yesterday afternoon has asked Mr. Waggener that he put his staff diligently to work preparing, insofar as possible in these days of inflation, advancing costs of budgets for the various projects. Your committee did agree that it would have a special meeting of the group again prior to the next meeting of this Board so that we might come up with specifics. The way things are going, we'll have to go up at least 10% to allow for inflationary pressures. When we have the budgets for the projects we have already approved, with or without fiscal notes, we are going to need additional sums. I am simply going to make the general statement to the Board at this time that your committee feels that obviously there is going to have to be a substantial increase recommended in the annual dues of this organization, and we will be back to deal with that later.

Doctor Scamahorn: You have to notify the membership so many days.

Mr. Waggener: I think the Board, Dr. Scamahorn, has the authority to bring in a resolution at the last minute without its being previously distributed. I think it would be well for the membership to be well aware of it well in advance.

Chairman Santare: May I make a suggestion that Dr. Goodman write up a resolution for dues increase and we merely leave out the percentage or numerical raise until it is finished, until it is completed. Some of the projections are very definite as Dr. Goodman said. Increase in inflation is 12 percent, not 10 percent this year, so your food is going up; your board, when you stay at a place like this or some place else, your wages, your Social Security—all are increasing—so they have a definite figure right now they can go with but they are not sure what the extent of the raise is going to have to be.

BUILDING PROGRAM RECONSIDERATION

Chairman Santare: The motion has been made by Dr. Holtzman that this matter be reconsidered.

The motion received a second and passed.

Doctor Holtzman: I would like to hear Doctor Wilhelmus' discussion of possible alternative.

Doctor Wilhelmus: This is what we discussed at the Executive Committee. I suggested, if you recall, one was for cost of $410,000 and one was at a cost of $510,000 for the expansion. It was brought out that we would be unable to sign contracts this year: the cost going up 20%, which increased the $410,000 up to $490,000 and the $510,000 up to over $600,000 for the extension of the building. My idea was simply to go a little slower. I cannot see inflation continuing this direction for the next few years. We could utilize the ISMA rental properties in the rear of the office for CHAMPUS and storage. That would give us x-number of square feet for operation for the next few years.

Chairman Santare: Your motion, Dr. Holtzman, then would be that we present the proposal for building program to the House?

Doctor Holtzman: Including the use of the residences, in lieu of building.

Chairman Santare: Dr. Holtzman, then you make your motion that this Board present its building program in its entirety to the House as presented by the Building Committee for action without recommendation.

The motion was seconded and passed.

MEDICAL PRACTICE ACT

Mr. McDermott: You should have received a copy of Draft 74-1. It is the only draft of this year. I did hear from the O & O Academy, as Dr. Santare pointed out, only with respect to two suggested changes—each one of those changes amounts to one word, so this is the most encouraging thing I have seen in a long time. Mr. McDermott explained the recommended changes.

Chairman Santare: The Board has now the ability to tell our Commission on Legislation to proceed with it and bring it back to the House, where we cannot approve it, but we were mandated by the House of Delegates to present this to the legislature.

Doctor Gosman: I move that this Board go on record and present this to our Commission on Legislation as amended.

The motion received a second and passed.

REPORT FROM THE MEDICAL-LEGAL REVIEW COMMITTEE

Mr. McDermott: The one question that seemed not to be resolved at the last meeting that Dr. Beeler wanted me to comment on was that of the Medical-Legal Defense Fund being used for physicians' attorneys who are involved in malpractice law suits. He checked back with the Medical Review Committee and simply wants it stated that, as he had mentioned at the last meeting, their feeling is that these funds should be used for attorneys who are "expert" in the defense of malpractice suits to review the activities of attorneys for insurance companies so that monies available would be for filing of amicus curiae briefs or redoing the work of other attorneys in defending some of our members who are being sued for malpractice; not necessarily, as perhaps has been in the past, to allow the physician to go out and select his own attorney who may or may not be an expert in this area for defense. The other point that Doctor Beeler wanted me to make deals with the subject that he feels, as many of you do, I am sure, is now in the crisis stage—the area of malpractice insurance. Last Wednesday, Dean Beering, Chancellor Irwin, Dr. Beeler, Bill Hall, and Cleon Faust, who is past dean of the law school, met to discuss the problem and are now investigating the possibility of using a system of binding arbitration for all of the physicians and house staff involved in the University Medical Center complex. They will attempt to determine whether it is feasible to inaugurate such a program. If you will review some of the material I sent to you on medical mal-

practice, you will find that Indiana does have an arbitration law.

Chairman Santare: There are two things which have been brought up and I would like to take them in order. First, the Medical Defense Fund—and I believe that would require constitutional change.

Doctor Gosman: I make the motion to the change, as recommended by the Medical-Legal Review Committee, that the State Medical Association has the right to hire a physician of competence in the medical-legal field to look over the shoulder of the attorneys.

Chairman Santare: The motion was made by Doctor Gosman and seconded that Section 3 be amended by the Commission on Constitution and Bylaws to be presented at the House of Delegates, the tenor would be deletion of the use of the money for an attorney of choice.

The motion was seconded and carried.

REPORT ON BOARD OF MEDICAL REGISTRATION AND EXAMINATION

Doctor Scamahorn: For your information, out of 5,500 doctors currently holding licenses in the state, the last three years we have cited 10 doctors. One we found not guilty on the charge of reckless homicide. The reason I'm giving this, as you run onto legislators they will tell you you're out to get the chiropractors; you're out to get the podiatrists; and you're out to get other groups. There are only 500 D.O.s and we have cited and revoked two licenses there. Podiatrists—200 and we have revoked two licenses in podiatry; 100 physical therapists and we revoked one license of physical therapy; and chiropractors, there are 300, and we have revoked two licenses in chiropractic. That's a total of 20 people in the last three years that we have had to have a trial; and believe me, one of them ran over four days of nine hours each. We stayed there almost 36 hours hearing testimony, interviewing patients, looking at x-rays, and so forth.

RECOMMENDATION OF COMMISSION ON PUBLIC HEALTH

Chairman Santare: (Reading from Commission's Report) "It was moved by Dr. Work, seconded by many, and carried, that it be recommended to the ISMA Board of Trustees that they encourage the Federal Department of Transportation and the Interstate Commerce Commission to include a statement from the appropriate law enforcement agency as a part of the physical examination form for truckers; such statement shall detail any record of alcoholism, accidents, narcotic use, psychiatric disorders; such statement to be cleared through or issued by the Bureau of Motor Vehicles as a licensure requirement."

You have read this and I am merely reading it again. The recommendation is that we encourage the Federal Department of Transportation and the Interstate Commerce Commission to include such statement from the appropriate law enforcement agency as part of the physical examination.

Dr. Wilhelmus moved acceptance of the motion. It was seconded.

Doctor Wilhelmus: I would change the original motion to encourage the Commission on Public Health to request the Bureau of Motor Vehicles to ask the questions on alcoholism and drugs, etc. and not ask doctors to do it.

There was a second by Dr. Thatcher to the amended motion.

Doctor Gosman: I wonder if it would be worthwhile to investigate this a little bit further and then have somebody come back to the Board at the next meeting with a more thorough discussion of it. Then we can vote on it.

Doctor Gosman then moved that the matter be tabled until the next meeting. There was a second and the matter was tabled.

STANDARD INSURANCE CLAIM FORM

Doctor Dukes: I know we did this at the AMA and we are currently talking to the Insurance Commissioner about it, but I thought we should bring it to our House of Delegates.

WHEREAS, Physicians are constantly required to fill out insurance report and claim forms from many insurance commercial insurers; and

WHEREAS, The insurance carriers have not standardized their report claim forms, thereby serving to confuse the physician and unduly complicate his work; now, therefore, be it

RESOLVED, That the ISMA take whatever action is necessary to make it compulsory that insurance carriers doing business in Indiana use and accept the standard claim form for physicians and patient claims and reports in this state.

Motion was made and seconded to send the resolution to the House of Delegates. Motion passed.

REPORT ON INDIANA EMERGENCY MEDICAL SERVICES COMMISSION

Doctor Farquhar: Inadvertently our legislators put a great deal of power into the Indiana Commission, stating that we should develop the quality standards for the entire system of emergency care, have them reviewed by the legislature and promulgated by the Governor, and then set about implementing the system. In order to do this, under the letter of the law and with the spirit of the practicing physician for the health providers, we have very carefully set down a report which is almost complete. I would like to summarize very briefly what is going to the legislature this fall and to the Governor for promulgation to take effect June 30 of next year through January of 1978.

Doctor Farquhar then detailed the substance of the forthcoming report.

REPORT FROM DOCTOR CORCORAN

Doctor Corcoran: Presently the AMA's eminence in medical education is being threatened seriously by at least three groups—The Association of American Colleges, the American Hospital Association, and the National Board of Medical Examiners. Even the Hospital Association is now wanting representation in the monitoring of undergraduate medical education, using the opening of graduate education through residency, and I'm quite concerned about losing and diluting the influence of the Council on Medical Education in this area. Secondly, as you know, I am chairman of the Committee on Licensure and Certification of the Council on Health Manpower, and this is coming along very rapidly. I didn't dream that it would develop to the degree that it has in the Federal Congress. In Comprehensive Health Planning we have been having a very unpleasant and painful lesson in Evansville, and I don't know how many of you in other parts of the state are being sensitized to this. I happen to be on the executive committee of CHP. Within the past year, several significant things have happened in our community. We have hospitals of 600 beds and a couple between 400 and 500-bed hospitals. They have become polarized. The staffs have become almost limited to single hospitals where we used to practice in all three. One of the hospitals was granted almost a monopoly on radiation. They got a linear accelerator through. They are now advertising their regional cancer center in the papers. The impact upon the physicians who try to treat malignancies in the other hospitals, within two or three years, is hard to assess. Then we developed recently open-heart surgery and Health Planning decided that a certain hospital would have it. This has now gone into the courts and our taxpayers' money is going to defend a decision which will have a many-fold impact. Very shortly, I think, we are going to be confronted in our community with a decision on which hospital or hospitals will have obstetrics, which are going to have high-level, high-risk pediatric units, which are to have emergency care, burn control or burn service, and there are a few others. The answer is that more concerned physicians must get into it, al-

though as providers they are being elbowed out of it; and consumers are taking over the control, even the chairmanships. I don't know the answer except the officers and trustees and the staff of the State Association, the delegates and the alternates should, I think, be encouraged to develop a good deal of expertise in depth in certain areas and try to correlate the information.

Doctor Farquhar. At one time ISMA had become involved when Dr. G. O. Larson was still alive and active in the State Health Planning Council. The legislative background for this is still there. HEW has simply decided not to fund state level comprehensive health planning, but it is still legal in our state to have a state health planning council. ISMA has the staff and has the expertise to do it. I would strongly recommend that we get back into that and take a near past president, a man known well about the state, who would be interested in using legal clout to accomplish this, and I would be willing to move that this Board mandate the reinstitution of the state Health Planning Council and that leadership be forthcoming from the Indiana State Medical Association.

The motion was seconded.

Doctor Dukes: Why don't we table this until the next meeting and appoint a committee to investigate how we are going to do this, how it will be funded, etc.

Chairman Santare: Doctor Dukes has made a motion to table to the next meeting with the provision, some of these seconding it before we repeat it, with the provision that a committee be appointed to research the information about funding and how it can be implemented.

Doctor Steen: In all due respect to the president, I don't really believe we need a committee. I think you have the knowledge within the staff of ISMA to put this out for you in a very short period of time. That's all you need.

Chairman Santare: The motion is made to table, and staff will investigate the mechanism for us.

There was a second to the motion. The motion to table passed.

The Board, then, on motion and a second which passed, adjourned to meet again during the State Convention, Thursday, Oct. 3.

About Our Cover

The Birthday Bird

The classical Chinese watercolor painting on silk which is reproduced on this month's cover was executed by Dr. W. P. Loh of Gary and won a first place award at the Art and Hobby Show held in conjunction with the 1971 Indiana State Medical Association Convention.

According to Dr. Loh, the Birthday Bird appears on any happy occasion—such as a birthday or New Year's Day—and we are happy to bring it to you at this Happy Holiday Season with best wishes from the editors and staff.

Reproduction of the painting in full color on 11 x 14-inch paper, suitable for framing, are available on request at no charge. Be sure to type or print plainly your name and address (including Zip code); we hope that the reprints can be mailed early in January but cannot set a definite date.

The center column of Chinese letters is the traditional "Merry Christmas and Happy New Year," while the left-hand column says "by Wei-Ping" and Dr. Loh's seal is reproduced. The column on the right reads "Birthday Bird."

Reproduction of the painting was partially made possible by the assistance of the Mary Rogers Fund.

THE WINNERS - - 125th Annual Convention

Indianapolis, Oct. 4-8, 1974

SCIENTIFIC EXHIBIT AWARD WINNERS

Awards for the excellence of the Scientific Exhibits at the 125th Annual Meeting were made to:

First place—John P. Donohue, M.D., and Laurence J. Gott, M.D., Indianapolis—The Case for En Bloc Cadaver Nephrectomies.

Second place—Laird G. Jackson, M.D., and associates, Philadelphia—Tay-Sachs Disease: Model for the Prevention of Genetic Disease.

Third place—Eugene D. Van Hove, M.D., and associates, Indianapolis—Tumorophilic Gallium-67 Localization.

GOLF TOURNEY WINNERS

Winners in the men's division were:

Longest Drive—Brad Bomba
Low gross: First—W. C. Polhemus
Second—Brad Bomba

Low net: First—Meredith B. Gossard
Second—James Topologus, Jr.

Next 12 low net—Irvine L. Zeiger, James Topologus, Sr., William Lybrook, Malcolm Wrege, F. C. Boggs, Robert Stone, George Poolitsan, Joseph F. Milan, James Higgins, Leslie M. Baker, W. R. Thompson and Norman K. Wilson.

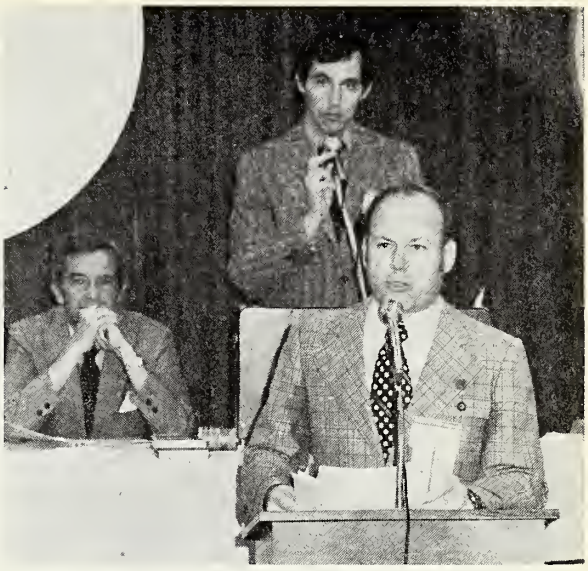
Among the women golfers the winners were:
Low gross: Betty Lybrook
Low net: Marie Donato

ART AND HOBBY SHOW

This year's show had to be canceled. It is hoped that next year's will be bigger and better than ever.

For aged, blind and disabled patients with limited income and resources, a new federal program began in January 1974: Supplemental Security Income. It replaced state and local public assistance for the aged, permanently and totally disabled, and the blind. Aid to families with dependent children, general assistance and the full range of welfare services continue under state direction.

The 1974 Convention Story



DR. JOHN W. BEELER, Indianapolis, speaker of the House (seated), and Dr. William R. Cast, Fort Wayne, vice speaker, listen intently while Dr. Richard Ingram, Montpelier, who was named chairman of the Board of Trustees for the coming year, addresses the House.





The House of Delegates



THE IMPAC LUNCHEON on Friday at the Hilton drew a large crowd to hear Harvard Law School Professor Arthur R. Miller.

CONGRESSMAN WILLIAM HUDNUT, an ordained minister, was the speaker at the brief church service Sunday noon which was followed by a luncheon sponsored by the Woman's Auxiliary. Mrs. Otis R. Bowen, president of the Auxiliary, is seated in front of the rostrum.



Award Winners





DR. HENRY W. EGGERS, Munster, received the 1974 Physician Community Service Award (which is provided through the courtesy of the A. H. Robins Co.) from Doctor Dukes.

DR. MERRITT O. ALCORN, Madison, received a Certificate of Appreciation from President Dukes for his many years of service to the State Board of Medical Registration and Examination and the ISMA.





MISS DEBBI LOWE, of WOWO Radio, Fort Wayne, was the winner of the ISMA journalism award for radio.

DON GRUBBS, city editor of the Peru Daily Tribune, won the newspaper category award for his story on venereal disease in the community.

MRS. BARBARA BOYD, Indianapolis, reporter for WRVT-6, received the television award for the reporting of her personal experience with breast cancer.

DR. MAURICE GLOCK, Fort Wayne, was one of 10 past presidents in attendance at the Convention who received a special certificate from Governor Bowen.



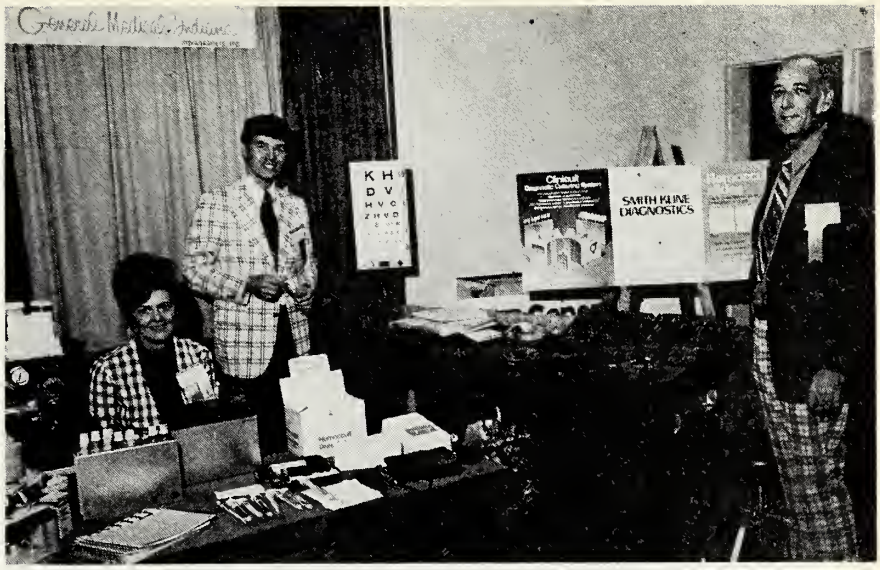






Reference Committee Meetings

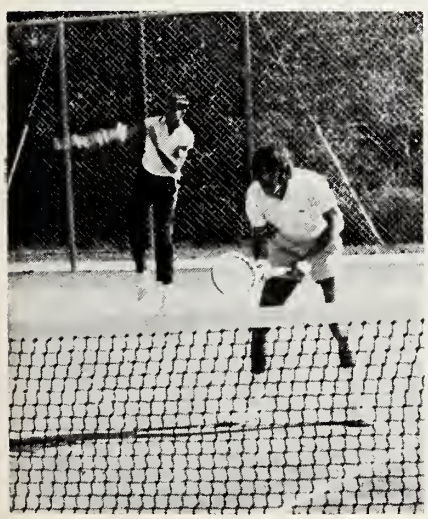


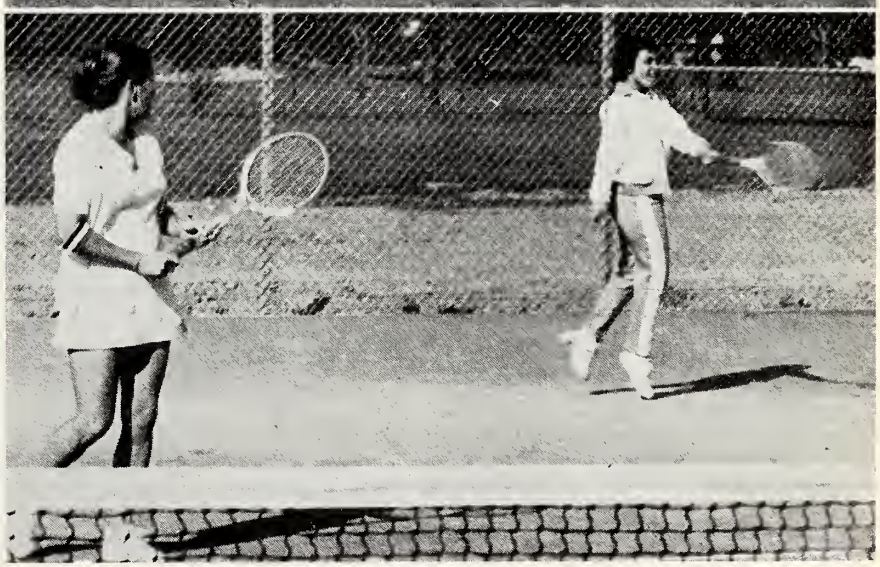


TWO of the many attractive technical exhibits and attendants that added to the impact of the 125th Annual Meeting.



GOLF and tennis tournaments were held at the Highland Golf and Country Club and participants enjoyed an informal hour and awards dinner Friday night at the club.







DR. AND MRS. GOETHE LINK (upper right) were among those who attended the dinner party at the Columbia Club of the Section on Surgery; the Indiana Chapter, American College of Surgeons, and the Indiana Chapter, International College of Surgeons.



Section and Specialty Meetings





DR. ROBERT YOHO, assistant state health commissioner, participated in the meeting of the Section on Preventive Medicine and Public Health.



ON HAND for the Editorial Board luncheon were (left to right): Drs. Lall Montgomery, Muncie; Samuel R. Mercer, Fort Wayne; A. W. Cavins, Terre Haute; Irvin W. Wilkens, Indianapolis; W. P. Loh, Gary; Paul S. Rhoads, Richmond; Frank B. Ramsey, Indianapolis, and Rodney A. Mannion, LaPorte.

THIS YEAR'S meeting of Small County Delegates attracted some of the delegates from larger counties. ↓











NO ISMA convention would be complete without a formal dinner; the above photographs were taken at the Board of Trustees' dinner at the Columbia Club.

AFTER the football game Saturday convention-goers attended an Oktoberfest at the Athenaeum which was sponsored by the Woman's Auxiliary.







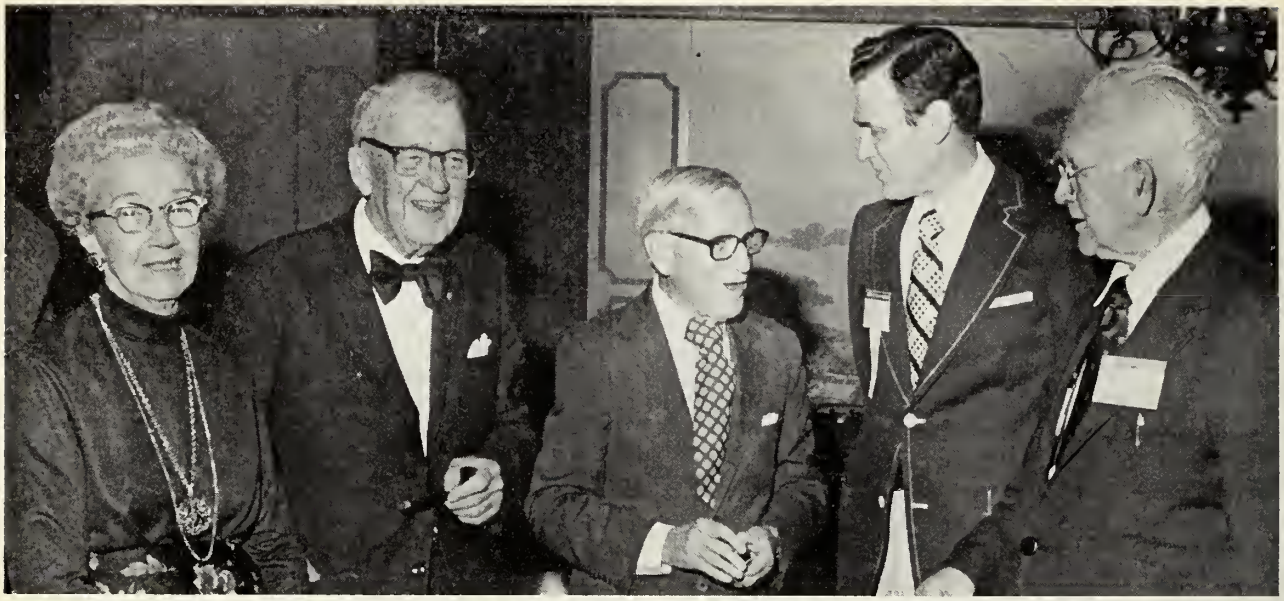








At the President's Dinner . . .







At the 50-Year Club Reception and the President's Dinner . . .



OUTGOING PRESIDENT Dr. Joe Dukes (right) no doubt had some words of advice for his successor, Dr. Gilbert Wilhelmus.





Convention Election Results

Dr. Vincent Santare Named President-Elect

DR. Vincent J. Santare, Munster, was elected president-elect of the Indiana State Medical Association at the closing session of the House of Delegates in October. He succeeds Dr. Gilbert Wilhelmus, Evansville, who was installed as president on October 8.

(An account of the career and service to organized medicine of Doctor Wilhelmus appeared in the November *Journal.*)

Dr. Hugh K. Thatcher, Jr. Indianapolis, was re-elected treasurer, and Dr. Arvine K. Popplewell, Indianapolis, was re-elected assistant treasurer.

Dr. Richard Ingram, Montpelier, was elected chairman of the Board of Trustees, while Dr. Donald M. Kerr of Bedford was renamed chairman of the Executive Committee, and Dr. William R. Clark, Fort Wayne, was re-elected to the Executive Committee.

Drs. John W. Beeler, Indianapolis, and William R. Cast, Fort Wayne, were re-elected speaker of the House of Delegates and vice-speaker of the House.

Dr. Alvin J. Haley, Fort Wayne, was the only new trustee taking office; he succeeds Dr. John S. Farquhar, Jr., who resigned to accept a position in Florida. Dr. Martin O'Neill, Valparaiso, who was elected a new Trustee for the Tenth District, succeeded Dr. Vincent Santare as trustee when Dr. Santare became president-elect.

Drs. Edgar R. Cantwell, Vincennes, and Franklin A. Bryan, Fort Wayne, are new alternate trustees, representing the Second, Tenth and Twelfth Trustee Districts, respectively. Alternate trustees who were re-elected were: Third District, Thomas Neathamer, Jeffersonville; Seventh District, Donald McCallum, Indianapolis; Ninth District, Max N. Hoffman, Covington, and Eleventh District, Lloyd L. Hill. Peru.

Trustees who were re-elected were: First District, Bernard Rosenblatt, Evansville; Fourth District, Howard C. Jackson, Madison; Seventh District, John O. Butler, Indianapolis, and G. Beach Gattman, Elkhart.

Dr. John O. Butler, Indianapolis, was elected a delegate to the American Medical Association, succeeding Dr. Eugene Senseny, Fort Wayne, and Drs. George Lukemeyer, Indianapolis, and Everett Bickers, Floyds Knobs, were elected alternate AMA delegates, succeeding Drs. A. Alan Fischer, Indianapolis, and Kenneth O. Neumann, Lafayette.

Drs. James Harshman, Kokomo, and Malcolm Scamahorn, Pittsboro, were re-elected AMA delegates, and Dr. Ross Egger, Daleville, was re-elected alternate delegate.

New Section Officers

Results of the various Section elections are as follows:

Section on Surgery: Chairman, Lowell Hillis, Logansport; vice-chairman, Robert Nagan, Indianapolis; secretary, Jay Grosfeld, Indianapolis.

Section on Internal Medicine: Chairman, Thomas W. Alley, Indianapolis; vice-chairman, Douglas H. White, Jr., Indianapolis; secretary, Charles W. Magnuson, South Bend.

Section on Family Physicians: Chairman, David M. Hadley, Plainfield; vice-chairman, Davis W. Ellis, Jr., Rushville; secretary, William T. Leffler, Indianapolis.

Section on Obstetrics and Gynecology: Chairman, Charles R. Thomas, Indianapolis; vice-chairman, James L. Mount, Bedford; secretary, Hans E. Geisler, Indianapolis.

Section on Ophthalmology and Otolaryngology; chairman Kenneth Isenogle, Fort Wayne; vice-chairman, Wallace Dyer, Evansville; secretary, David Kenney, Indianapolis.

Section on Anesthesiology: Chairman, W. W. Stogsdill; vice-chairman, Normand Townley; secretary, R. K. Stoelting, all of Indianapolis.

Section on Public Health and Preventive Medicine: Chairman, Robert M. Seibel, Nashville; vice-chairman, Ivan T. Lindgren, Aurora; secretary, David J. Edwards, Indianapolis.

Section on Radiology: Chairman, L. Ray Stewart, Evansville; vice-chairman, David Gastineau, Fort Wayne; secretary, John Knote, Lafayette.

Section on Nervous and Mental Diseases: Chairman, Gene E. Lynn, Indianapolis; vice-chairman, Iver F. Small, Indianapolis; secretary, Richard N. French, Jr., Indianapolis.

Section on Pathology and Forensic Medicine: Chairman, Robert Costin, Indianapolis; president-elect, J. D. Hubbard, Indianapolis; secretary, Victor Muller, Indianapolis.

Section on Pediatrics: Chairman, George F. Parker, Indianapolis; vice-chairman, John R. Poncher, Valparaiso; secretary, Robert M. Sweeney, South Bend.

Section on Directors of Medical Education: Chairman, John L. Cullison, Muncie; vice-chairman, W. Thomas Spain, Evansville; secretary, Stephen R. Stouder, Indianapolis.

Section on Cutaneous Medicine: Chairman, Victor G. Hackney, Indianapolis; vice-chairman, William B. Moores, Indianapolis; secretary, Emanuel C. Liss, South Bend.

Section on College Health Physicians: Chairman, James R. Greenlee, Bloomington; secretary, Floyd Thurston, Bloomington.

Section on Allergy: Chairman, Irvin Caplin, Indianapolis; vice-chairman, William Mount, Lafayette; secretary, Julian Kaufman, Fort Wayne.

Section on Urology: Chairman, Frank B. Adney, Jr., Richmond; secretary, Russell L. Judd, Indianapolis. ◄

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1974

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House of Delegates Proceedings

October 4, 7 and 8, 1974

INDIANAPOLIS SESSION

The first meeting of the House of Delegates convened at 9:00 a.m., EST, Friday, October 4, 1974, in the Ballroom of the Columbia Club, Indianapolis, with Dr. John W. Beeler, speaker of the House of Delegates, Indiana State Medical Association, presiding.

The second meeting of the House was convened at 2:00 p.m., Tuesday, October 7, in Rooms 210-212 of the Indiana Convention-Exposition Center, and the final meeting was held at 2:00 p.m., Wednesday, October 8.

Invocation was given by Dr. Malcolm O. Scamahorn, Pittsboro.

In Memoriam

Following is a list of members of the Indiana State Medical Association who were members of the House of Delegates or who served the Association in an official capacity and who have died since the 1973 annual session.

PAUL B. ARBOGAST,
Vincennes
MAYNARD M. AUSTIN,
Evansville, formerly Anderson
EDWIN B. BAILEY,
Linton
GEORGE K. BALSBAUGH,
North Manchester
WINSHIP C. CALLAGHAN,
Greensburg
JOEL CARNEY,
Jeffersonville
HENRY G. COLEMAN,
Salem
MERRILL S. DAVIS,
Marion
JOSEPH R. EASTMAN, JR.,
Indianapolis
FRED FLORA,
Frankfort
IVAN L. GAILEY,
Newburgh
JAMES W. GRIFFITH,
Sheridan
MYRON S. HARDING,
Indianapolis
CARL P. HUBER,
Indianapolis
WALTER E. KRUSE,
Fort Wayne
ALBERT T. JONES,
Anderson
ROBERT E. KINNEMAN,
Greenfield
WILLIAM A. KURTZ,
Tipton
BYRON L. LINGEMAN,
Crawfordsville
PIERCE MAC KENZIE,
Evansville
J. FRANK MAURER,
Brazil
R. C. MEYER,
formerly Vincennes
KENNETH R. OCKERMAN,
Rensselaer
WILLIAM F. OREN,
South Bend
ARTHUR A. RANG,
Washington
ARTHUR W. RECORDS,
Franklin
LESTER L. RENBARGER,
Marion
D. HAMILTON ROW,
Indianapolis
KARL R. RUDDELL,
Indianapolis
TOM SHIELDS,
Richmond
S. LEWIS STERN,
Sarasota, Fla., formerly Hammond
DEAN K. STINSON,
Rochester
JOHN M. SULLIVAN,
Terre Haute
RAY THARPE,
Indianapolis
WILLIAM NILES WISHARD, JR.,
Indianapolis

Report of Credentials Committee

Dr. John O. Butler, chairman of the Credentials Committee, reported 105 delegates, 9 alternate delegates, 6 officers, 10 trustees, 7 alternate trustees and 11 past presidents in attendance at the first meeting. The chair announced that, inasmuch as 50 constitutes a quorum, there was a quorum present for the first session of the House of Delegates. Attendance at the second meeting was 103 delegates, 5 alternate delegates, 6 officers, 14 trustees, 8 alternate trustees and 9 past presidents. At the last meeting the attendance was 100 delegates, 5 alternate delegates, 14 trustees, 1 alternate trustee and 8 past presidents.

Dr. Lester Hoyt, Indianapolis, served as parliamentarian for the House of Delegates.

Approval of Minutes

The proceedings of the 124th annual meeting of the House of Delegates held in Indianapolis, Indiana, and published in the December 1973 JOURNAL of the Indiana State Medical Association were approved upon motion duly made and seconded and carried.

Introduction of Guests

The speaker introduced Dr. Malcolm Todd, president of the AMA, who spoke to the delegates at the first meeting of the House. Also introduced were Dr. James Henry, president, Ohio State Medical Association; Dr. Hoyt D. Gardner, president, Kentucky Medical Association; Dr. Brooker Masters, president, Michigan State Medical Society; Dr. Ralph L. Wicks, president, Iowa Medical Society; Dr. Fredric Lake, president, Illinois State Medical Society, and Dr. William E. Gilmore, president, West Virginia State Medical Association, and Mr. Fremont Power, Executive Director of the Indianapolis News.

Address of the President

HOUSE ACTION: Ordered filed

Why does the public persist in using the physician's house call as a measuring stick of medical service? Clinically, it has little value in an age when our technical requirements far transcend the little black bag. Its popular appeal has only one explanation—it is a symbol of concern and compassion. By today's standards, the tie between the patient and his doctor is still strong. Medicine still outranks every other occupation in popular esteem, as the polls indicate. And since our profession has two-and-one-half-million daily contacts with patients, we have an ample opportunity to show our people that we really do care about their human needs. These millions of contacts should compound the good will toward our profession. Yet, our collective relationship to society has suffered more than the individual doctor-patient relationship. Many people who have the fondest regard for their personal physician are cynical toward our profession, toward our performance on a social level.

The mixed attitude is reflected in a recent survey. It showed that only 10% of the people are not satisfied with the quality of care they receive, and only 38% feel the out-of-pocket cost is higher than it should be. Yet, 76% have been led to believe that a health-care crisis exists.

Why does a majority suppose that a crisis rages—despite the absence of any crisis in its personal care? Frankly, this crisis, like some others before it, has been manufactured by influential forces whose interests it serves. Abstract impressions are easily created in our quickly communicative society. Sad truths about the medical and financial gaps in

care become mixed with hearsay—exaggerated reports—and a stacked deck of statistics—until there is a jumble of notions that are being exploited politically.

But what do the facts say? They say we have the best health-care system in the world, the best-trained physicians, nurses, and allied personnel, the best hospitals, health-care institutions, and facilities, and more of them. The facts say that our people are receiving more and better care than those anywhere else. Our quality of care was never better and our population was never healthier. In short, in my opinion, there is no health-care crisis.

Many of the programs and plans from Washington are as false an abstraction as the crisis they are designed to meet. Some of them are so vague and complex that they can be understood only with the passage of time. Regardless of how devious or complex they are, however, they have a direct, simple appeal. They give a sham appearance of human concern. Many men in high office assert that government is ready, willing and able to fill those voids of concern that we doctors have created or tolerated.

We can answer their pronouncements and plans point by point, charge by charge. But actually we face an even larger need. We must achieve a new understanding between ourselves and society. We *must*—and we *can* convince the people that we have far more human concern for their medical well being than any government or any politician has. We *must*—and we *can* bring it home to the people that government's approach to care is essentially cold and mechanical—an intellectually arrogant obsession with rules, regulations, sociological blueprints, computer printouts, file copies, and all the other paraphernalia of the "Think-Tank Revolution."

All the activities of the ISMA and its component societies should be directed to offsetting some of these misconceptions and false hopes that are being raised by third parties and government. We should continue in this direction.

Commissions and Committees of the Association have continued their fine work this past year. Throughout my report I will make continuous reference to some of the highlights of their activities since, in the final analysis, they, the Board of Trustees, and the Executive Committee are the extensions of the policies and plans stipulated and directed by the House of Delegates.

Attendance at the commission and committee meetings reached a new all-time high for participation. As president, I asked the staff to personally call members who had not responded to the written notices of their meetings and the subsequent result in attendance proved the procedure to be worthwhile.

Public relations-wise, we've witnessed this past year the growth of the Tel-Med telephone health information service to a statewide operation. Telephone calls from the far corners of Indiana have averaged 800 a day. Indiana is the first state in the nation to expand this program to the entire state and, as you recall, was the second state to inaugurate the program. Without doubt, this service has been one of our best public relations efforts. Hoosiers have praised the service; and with but a few exceptions, the service has been warmly and enthusiastically accepted.

At the same time, the Speakers Bureau has evolved from the actions of the 1973 House and the subsequent activity of the Public Information Commission. With the quality of speakers being enlisted by the Commission, there is no question about the ultimate benefit of this service to our county societies; our Auxiliary can aid in promoting our bureau to the public and its numerous organizations. With these activities we are accomplishing two goals in informing people on matters of health in which they are vitally interested and in matters of socioeconomic importance which have impact upon their hospitalization costs, medical care and treatment, and prevention of disease.

In a spirit of unity and cooperation we continue to establish closer working liaison with the Indiana Academy of Family Practice in a number of areas. The Future Planning Committee of the Association has suggested that efforts be made to combine scientific meetings with the Academy and the School of Medicine in an effort to attract more Indiana physicians to the meetings and to upgrade the quality of program.

In addition to this, the Academy, through its Public Relations Committee, has expressed a desire and willingness to work with us in promoting and utilizing the Speakers Bureau of the ISMA. They have also recommended that a combined ISMA and IAFP speakers' workshop be held, utilizing the AMA or other speakers' training courses for physicians.

I believe this trend toward combining our resources, programs and efforts in the interests of organized medicine is much needed trend in these times when organized medicine would seem to be splitting into so many segments. There is a joint committee now active concerning this area. Such fragmentation can only lead eventually to such division that the unified forces which work against our medical care system will eventually cause our capitulation. Fragment by fragment, the concept is known as "divide and conquer."

PSRO legislation and regulations are among the current issues which have divided us throughout Indiana as a profession; and, for that matter, the same situation exists throughout the nation. The hard truth of the matter is that the law does exist. And one of the principles of medical ethics is that the physician should observe all laws—Section 4 of the Principles of Medical Ethics, to be exact.

The action of this House has stated that the Indiana State Medical Association is opposed to the concept of PSRO. At the same time, PSROs are being developed, both on a state and regional basis, and respected Indiana physicians are involved in these formations.

Realizing that we must adhere to the principle of opposition, we must recognize the fact, too, that these PSROs will meet the requirements of the law. We as an organized body must stay an arm's length away from these bodies by virtue of our stand on the issue; but we cannot, I feel, deny the fact that as long as these PSROs are under the control and influence of physicians we are in a better position than having them controlled and regulated by other groups or third parties.

By the same token, the medical profession should remain united in taking the legitimate paths to altering the law, either by continued effort to have the law repealed or by amending the law to eliminate its objectionable features. As your president, I feel that this approach is proper and acceptable and I believe we must develop the unification of thought and action to accomplish the aforementioned objectives.

Future planning becomes more predominant in this age of so many rapidly developing and constantly changing patterns of skills, improvement in technology for greater production output and data gathering, and the enormous growth of medical information made available day by day.

Continued emphasis must be given to the physician's continuing education and the stimulation to physicians to attend top quality medical seminars and discussions. In conjunction with this thought, the Convention Arrangements Commission of the ISMA would benefit greatly by utilizing each year the services of the past president of the Association in the capacity of Convention Arrangements Co-Chairman. As president he has had an opportunity to attend numerous state medical society conventions which, of course, offer him a broad variety of fresh ideas to make the ISMA convention more attractive to member-physicians.

I cannot emphasize too strongly the impact of the activities of the commissions and committees. But I do not have the time here to relay to you all of these activities. Many members work conscientiously to resolve issues and develop programs through the organization structure and I am convinced of the importance of attendance at the meetings and

of the need for the contribution of thoughts and ideas by every member.

During this past year the Commission on Special Activities, in an effort to streamline the commission and committee structure of the ISMA, gathered an enormous volume of suggestions on improving the organizational structure from past presidents and commission and committee chairmen. In looking at the data, there seems to be an overwhelming attitude on the part of all involved that this structure should be changed to accommodate the current necessity to meet problems of the profession in a more efficient manner and with more speed.

Additionally, you will have before the House the revised Medical Practice Act. There have been many hours of hard work and thought given to this matter, and the Commission on Medical Education and Licensure and the Commission on Legislation have worked conscientiously in their deliberations. However, I hope the House studies this very carefully. I still have reservations about this being introduced in the next legislature. And I believe my concern is well-founded. I am told we can achieve what we want through regulation.

We live in an age of specialists. The ramifications of Association activities call for these specialists. Lobbying is a full-time operation and calls for a person with in-depth knowledge of the government process and the laws and regulations which govern that process. Legal issues appear at every turn and can only be managed and directed by one trained in legal matters. Possibly our delegates to the AMA should be selected; that is, to represent a certain field.

Association management is the responsibility of one skilled and trained in these processes. Publicity and public relations is a field which calls for experience and education in dealing with the media, in speech writing, and promotion. Skilled, well-trained, intelligent office staff can not only produce the materials requested by the profession but can be of excellent service to the organization's committees and commissions. With careful selection of these professionals, the savings in terms of dollars expended can be great. They are more important than equipment. Such people know how to produce and can do it efficiently and effectively.

The Future Planning Committee must consider where the Association is headed and what its needs will be in 5, 10 and 20 years in terms of staff, equipment and programming in its many areas of concern.

The role of this committee becomes more urgent to the welfare of the Association with each passing year.

We are entering the most revolutionary period in our history. Our political system and educational structures are racing toward obsolescence, and very little fresh thinking is being done about how to save or replace them.

In the next five years all of us will be required to deal with more change than we have ever had to handle—changes in our life styles, our politics, our schools, churches and families. The last election and a relative calm on the campus ought not to deceive us unless we learn new strategies for coping, many of us will fall victim to adaptational breakdown.

Mark Twain is said to have remarked that he was concerned with the future because that was where he was going to spend the rest of his life. How to prepare for that great unknown? Attitude is of utmost importance. When stepping forward we should be prepared to think in terms of yesterday's procedures and use them for a guide to our future. One major corporation in the '50s gave careful study to the potential future uses of copying machines and came to the arresting conclusion: "Nothing will ever replace carbon paper." Its corporate face is red.

We must not only take the step forward but we must be ready for it. After tremendous initial enthusiasm a few years back for data processing, computers and management information systems involving huge investment in such systems, there began to be disgruntled customers who called the systems failures. What was really the failure? The system was usually doing exactly what it promised—generating a great deal of information to be used in decision-making. The problem was that many people did not know what information they needed or wanted nor do we know what they do with that information. As in nature, those who adapt, survive.

We in organized medicine are experiencing "future shock" now. Tomorrow is here now. Organized medicine cannot delay in gearing itself to meet the challenges placed before it today; and, beyond that, to be constantly evaluating our own status and condition to stay one day ahead—and not 20 years behind.

Remarks of Speaker Beeler

Any delegate may introduce a resolution from the floor provided that where a resolution has been first submitted to the Committee on Rules and Order of Business together with a written statement setting forth the reason why said resolution was not mailed to the Executive Secretary more than 45 days prior to the meeting of the House of Delegates and also setting forth in said written statement the reason why said resolution is of such an emergency nature that it cannot wait until the next meeting of the House, and that said Committee on Rules and Order of Business has approved said resolution for submission to the House, and that each delegate shall be furnished a copy before the next meeting of the House, then this subsection of the Bylaws may be suspended with respect to said resolution upon a two-thirds vote of the House of Delegates.

Committee on Rules and Order of Business is in session in the Foyer of the Ballroom.

Appointment of Reference Committees

In accordance with the Bylaws, I have appointed reference committees, and the names of the members of these committees are published in the Handbook.

These reference committees are to serve during this annual convention only and should not be confused with the commissions or standing committees of this Association.

To these reference committees will be referred all reports, resolutions and measures presented to the House of Delegates at this session, except such matters as properly come before the Board and and the recommendations of these committees shall be submitted at the second meeting of the House of Delegates at 2:00 p.m., Monday, October 7, for acceptance in the original or modified form, or for rejection. The Monday afternoon meeting will be held in Room 210-212 of the Convention Center.

Each reference committee consists of at least five members; the first member named is chairman. Will committee members please stand as their names are called?

REFERENCE COMMITTEE ON RULES AND ORDER OF BUSINESS

Thomas C. Tyrrell, Hammond (Lake), *Chairman*
Thomas J. Conway, Terre Haute (Vigo)
George T. Lukemeyer, Indianapolis (Marion)
Donald C. McCallum, Indianapolis (Marion)
Glen Ward Lee, Richmond (Wayne-Union)

REFERENCE COMMITTEE NO. 1

Thomas C. Tyrrell, Hammond (Lake), *Chairman*
Richard R. Eggers, Crawfordsville (Montgomery)
William R. Cast, Fort Wayne (Allen)
C. David Ryan, Columbus (Bartholomew-Brown)
Max N. Hoffman, Covington (Fountain-Warren)
Fred L. Toumey, Indianapolis (Marion)

REFERENCE COMMITTEE NO. 2

Thomas J. Conway, Terre Haute (Vigo), *Chairman*

Paul W. Holtzman, Bloomington (Owen-Monroe)
Peter E. Gutierrez, Crown Point (Lake)
Richard A. Brickley, Indianapolis (Marion)
Douglas H. White, Indianapolis (Marion)
John D. Wilson, Evansville (Vanderburgh)

REFERENCE COMMITTEE NO. 3

George T. Lukemeyer, Indianapolis (Marion), *Chairman*
John G. Pantzer, Jr., Indianapolis (Marion)
J. Franklin Swaim, Rockville (Parke-Vermillion)
Wilbert McIntosh, Riley (Vigo)
George M. Haley, South Bend (St. Joseph)
John A. Knote, Lafayette (Tippecanoe)
Raymond H. Murray, Indianapolis (Marion)

REFERENCE COMMITTEE NO. 4

Donald C. McMcCallum, Indianapolis (Marion), *Chairman*
Lloyd L. Hill, Peru (Miami)
Norbert M. Welch, Vincennes (Knox)
B. T. Maxam, Indianapolis (Marion)
Wallace S. Tirman, South Bend (St. Joseph)

REFERENCE COMMITTEE NO. 5

Glen Ward Lee, Richmond (Wayne-Union), *Chairman*
I. E. Michael, Indianapolis (Marion)
Barbara B. Backer, LaPorte (LaPorte)
Donald C. Chamberlain, South Bend (St. Joseph)
Martin J. O'Neill, Valparaiso (Porter)
Kenneth L. Gray, Indianapolis (Marion)

CREDENTIALS COMMITTEE

John O. Butler, Indianapolis, (Marion), *Chairman*
Charles R. Thomas, Indianapolis (Marion)
Eugene S. Rifner, Van Buren (Grant)
Kenneth O. Neumann, Lafayette (Tippecanoe)

TELLERS

Robert M. Seibel, Nashville (Bartholomew-Brown), *Chairman*
Everett E. Bickers, Floyds Knobs (Floyd)
Richard G. Ingram, Montpelier (Delaware-Blackford)
G. Beach Gattman, Elkhart (Elkhart)

AMA Delegates and Alternate Delegates

The following were elected to a two-year term as delegate and alternate delegate to the American Medical Association, their terms to expire December 31, 1976:

Delegate, John O. Butler, Indianapolis; alternate, George T. Lukemeyer, Indianapolis; delegate, James A. Harshman, Kokomo; alternate, Ross Egger, Daleville; delegate, Malcolm O. Scamahorn, Pittsboro; alternate, Everett E. Bickers, Floyds Knobs.

Selection of City for 1979 Meeting

It was moved, seconded and carried to hold the 1979 meeting in Indianapolis. Dates to be set by the Board of Trustees.

Amendments to the Constitution

House Action: Adopted as amended. Sec. 4, ARTICLE IV amended to read as follows:

Sec. 4. Student members—Students who hold active membership in the Indiana Chapter of the Student American Medical Association shall have all the rights and privileges of this Association and shall select one delegate and one alternate delegate. The delegate, or in his absence, the alternate delegate, shall have all the rights and privileges of the House of Delegates with the power to vote.

Article IV, Composition of the Association

Be It Resolved that Section 1 of Article IV be amended by striking the entire Section 1 as now printed and substituting the following:

Section 1. This Association shall consist of Active Members, Associate Members, Interns and Residents, Senior Members, Honorary Members, Disabled Members, Distinguished Members, Military Service Members, Public Health Service Members, Retired Members and members of the Indiana Chapter of the Student American Medical Association.

Be It Further Resolved that Section 4 of Article IV be renumbered Section 5 and that a new Section 4 be substituted to read as follows:

Sec. 4.—Student members.—Students who hold active membership in the Indiana Chapter of the Student American Medical Association shall have all the rights and privileges of this Association and shall select one delegate and one alternate delegate. The delegate, or in his absence, the alternate delegate, shall have all the rights and privileges of the House of Delegates with the power to vote.

(Old Sections 5 through 8 to be renumbered 6 through 9)

Be It Resolved that Section 9 of Article IV of the Constitution be renumbered Section 11 and a new Section 10 be substituted to read as follows:

Sec. 10.—Military Service Members and Public Health Service Members.—Any physician who is actively engaged in the military service or public health service shall be eligible for membership in the Association with payment of reduced dues, they shall receive THE JOURNAL.

Be It Further Resolved that in addition to being renumbered Section 11, Section 9 of Article IV of the Constitution be amended to read as follows:

Sec. 11.—Rights and Privileges of Members.—Active members, intern and resident members, senior members, military service members, public health service members, disabled members, honorary members, student members and retired members shall have the same rights and privileges except as follows:

a. Senior members shall not be required to pay membership dues in the State Association.

b. If senior members desire to receive THE JOURNAL of the State Association, they shall pay the regular subscription price therefor.

c. Senior members who desire the benefit of medical defense as provided by the Bylaws of this Association shall pay the amount stipulated in Section 1, Chapter XXXIV of the Bylaws for this coverage.

d. Honorary members hereafter elected shall hold such membership as an honor and distinction and shall have the right to attend meetings of the Association. They shall have the privilege of participating in discussions but shall have no right to vote or to hold elective office. They shall not be required to pay membership dues in the State Association. Such honor may be conferred by the vote of the House of Delegates.

e. All such disabled members, as defined in Chapter IV, Section 9, shall receive membership cards and THE JOURNAL of the Association without charge.

f. Student memberships may be represented in the House of Delegates with all the rights and privileges and the power to vote. They shall be entitled to send one delegate or one alternate who are members of the Indiana Chapter of the Student American Medical Association. They are to receive THE JOURNAL of the State Association.

g. Retired members who have chosen voluntary retirement from the practice of medicine before the age of 70 shall only be required to pay membership dues in the amount of one half of the full membership dues applicable at the time of retirement.

Election of Officers

OFFICERS: Dr. Gilbert M. Wilhelmus of Evansville assumed the office of president and Dr. Vincent J. Santare of

Munster was elected president-elect.

Dr. Hugh K. Thatcher, Jr., Indianapolis, was re-elected treasurer by acclamation.

Dr. Arvine G. Popplewell, Indianapolis, was re-elected assistant treasurer by acclamation.

Dr. Richard G. Ingram of Montpelier was elected chairman of the Board of Trustees. Dr. Donald M. Kerr, Bedford, was re-elected chairman of the Executive Committee and Dr. William R. Clark, Fort Wayne, was re-elected a member of the Executive Committee.

Dr. John W. Beeler, Indianapolis, was re-elected speaker of the House of Delegates and Dr. William R. Cast, Fort Wayne, was re-elected vice-speaker of the House of Delegates.

Election of Trustees

Dr. Alvin J. Haley, Fort Wayne, was elected Trustee of the Twelfth District to fill the unexpired term of Dr. John S. Farquhar, Jr., resigned. Dr. Martin J. O'Neill, Valparaiso, was elected new trustee for the Tenth District in 1974. Four trustees re-elected in 1974 were: Dr. Bernard B. Rosenblatt, Evansville, First District; Dr. Howard C. Jackson, Madison, Fourth District; Dr. John O. Butler, Indianapolis, Seventh District; Dr. G. Beach Gattman, Elkhart, Thirteenth District.

Dr. Edgar R. Cantwell, Vincennes, was elected in 1974 alternate trustee for the Second District and Dr. Franklin A. Bryan, Fort Wayne, was elected in 1974 alternate trustee for the Twelfth District. Four alternate trustees re-elected in 1974 were: Dr. Thomas A. Neathamer, Third District; Dr. Donald C. McCallum, Indianapolis, Seventh District; Dr. Max N. Hoffman, Covington, Ninth District and Dr. Lloyd L. Hill, Peru, Eleventh District.

Address of President-Elect Gilbert M. Wilhelmus

HOUSE ACTION: Referred to the Board of Trustees

Distinguished delegates and my colleagues, in this, my initial address to this House of Delegates, I wish to stress my commitment to serve this body, the Indiana State Medical Association and the public, to whose care we are all dedicated. I decided that I could best serve, *not* by relating how great our general condition *is,* but by detailing just how it could be *better.* So after carefully deliberating, researching, outlining, finally I can articulate to you this morning four ideas over which I have labored and about which I have great concern and interest. I want to share these with you, and to humbly request your interest in, and support of any or all you deem significant and relevant.

I visualize the medical association as a business; and our business is humanity. As a humanitarian business, we can be sensitive to the inevitable changes all about us, and we can therefore change in the way of *progress.* Or we can be *insensitive* to the new demands of our age, and *not* change, and some will call it *regress.* During my tenure as your president, I wish us to *progress* in many ways. And the first requirement for such progression is cooperation, teamwork, the united effort and sincere support of *all* of us. I envision a teamwork that grows beyond this room and encompasses all physicians, all patients, yes, even the entire society. The team spirit I have in mind starts right here, right now! I solicit your attention to four proposals that I hope will excite you, as they have me, and that I hope will help to forge the teamwork that the coming year demands.

Proposal number one: The creation of a patient's compensation board

The cost of malpractice is increasing yearly, not only the obvious costs of time, effort and momey, but also the terrible cost of reputation, the erosion of trust and faith in the physician. And we know so many of the claims are baseless, foundless, illogical—yet still damaging. Is there any answer to this increasing dilemma? Yes! As I see it, if large and small corporations, such as IBM, Whirlpool, General Electric, have Workmen's Compensation Boards, then why cannot we, as physicians, have such a board? I think we should strive among our own society, as well as with legislature, to have what I will call, A "Patient's Compensation Board." This board could be made up of members of the medical profession, the legal profession and representation from the public. If a patient believes he has good cause for suit, instead of immediately suing his doctor, he could take his cause before the "Patient's Compensation Board." If it is a legitimate complaint, the patient could be remunerated properly by the same measures as workmen's compensation. A handbook of complaints and costs, similar to those used by Workmen's boards and by insurance companies, could be written. And a law could be written to state that if a patient receives satisfactory remuneration from the P.C.B., he would not have the right to return legal suit against the physician. However, if a patient desires, he could forego the P.C.B. and sue directly, if, of course, he believes his case warrants such action. As I visualize the creation of a Patient's Compensation Board, it would eliminate the majority of malpractice suits. Therefore, the patient would benefit, the doctor would benefit, the now clogged courts would benefit, and the public would benefit. But the creation of such a board will be the result, not of my efforts, but of ours, a result of cooperation, of teamwork.

Proposal number two: the formation of a medical ethics committee

The physician occasionally hears of a physician's problem: perhaps it is overuse of alchoholic beverages, perhaps financial trouble, or perhaps friction with his colleagues. A committee could be established so that troubled doctors would have a direct place to go, with accessible and interested colleagues, where problems could be analyzed, investigated if necessary, and eliminated before they become publicized and prolonged, which would be detrimental to themselves and to the medical profession, as well as to the community.

When a physician is responsible for an action that would lower the professional standard of the association, the purpose of the medical ethics committee would be to investigate, counsel, guide the troubled members of the Indiana State Medical Association. This committee would serve in a "watch dog" capacity, and would be alert for matters concerning medical ethics and professional relationships. It could investigate rumors and reports of unethical conduct and, above all, it should seek, in a friendly fashion, to advise and counsel members in these matters, and use this committee towards guidance, conciliation, and arbitration. This committee could have the power to hold hearings, and to request members to appear before it; this committee could then have the power as an impersonal group to present evidence to the board of trustees when it feels such action is warranted. I repeat: the committee's recomendations would be only for guidance. I know such a committee is workable and advantageous. Such a committee has been operating in one of the societies of our state, and has proved to be very effective. I am convinced that a medical ethics committee would be a great asset to our association. But teamwork from us all is needed, not only to initiate such a committee, but also to make it serve us, as I know it can.

Proposal number three: the development of medical education in our public schools

I believe that physicians should become more involved in the education of our children, particularly at the high school level. Oh, I know there are dedicated teachers in the areas of health and safety, but many are ill-prepared by education and particularly experience to deal with the multitude of problems and questions our teenagers have—such as drugs, sex, venereal disease and many more. I have had many opportunities to speak to high school classes and stud-

ents are *eager* to listen to people who *know*, especially who know through experience, who have learned firsthand. They are eager to learn from professionals who visit them because these professionals are truly interested in them, and not in testing or grading, or in the academic procedures.

In order to develop more sound medical education in our schools, I recommend that the Indiana State Medical Association request the State Board of Education to develop a program that would invite physicians to visit their local schools. How excellent it would be if every high school could have the personal contact of a physician—say one hour a day, for at least a week each school year—who would go into the classroom to give our students firsthand knowledge and a more thorough explanation from a medical standpoint of the physiology of the human anatomy, current trends in treatment of venereal diseases, abuses of drugs and alcohol, just to name a few of the needed subjects.

But, to carry out this proposal for the development of medical education in our schools any further, we need concerted effort, we need *teamwork*. And now, my final proposal.

Proposal number four: what we can do about government in the medical profession?

At one time the Indiana State Medical Association leadership centered its energy largely on the advancement of scientific matters, but times have changed, and this is no longer our sole objective. The successes on the scientific front have been so numerous and so striking that they created new challenges, and one challenge was "quality evaluation." There was little notice when on Oct. 3, 1972, President Nixon signed Public Law 92-603. There is no doubt on the part of friends and foes alike that this is the most radical health legislation in our country's history—the establishment of mandatory cost and quality control for large segments of the health care industry. It requires physicians to open files and hospital records to outside inspectors. The heart of this new federal control is a network of review boards to be established. Each will be charged with defining accepted norms of medical aid, and with insuring that individual physicians and hospitals meet specific standards of performance. We doctors must remember that what government pays for—it regulates, and, perhaps, controls! Therefore, I am convinced we must assist in making amendments to previous and to future legislation.

I believe this is required: This House of Delegates must give our Board of Trustees guidelines regarding exactly what we doctors of this state wish. Presently a dozen or more congressional committees are interested in health care, and most of you heard President Ford request that congress hurry to enact health care legislation. It is imperative that we unite, first here in Indiana, and then across the nation, to show the government and the public that the answer to health care is with the professionals, the physicians. So let us work diligently, now, to concur on specific guidelines.

Of course, it would be good business to give our board some leeway, because we doctors know that when we treat a patient, a prescribed treatment is given, yet sometimes symptoms and complications force us to alter the therapy, often at very short notice. This is similar to the Board's relationship to legislation which will affect medical practice. We must have a continual "updating," a continual "diagnosing," of our positions with the rapid change of events which have and are occurring, as government continues to become more involved with health plans and problems.

Let us remember that private practice is the bulwark of American medicine. The majority of physicians in this country caring for patients are engaged in private practice. and most Americans receive their care from private practitioners. America is great, because it has strong private business. American medicine in the *envy* of the world because it is privately practiced. The battle over privacy has gone on many years, and the war is far from over. We might have lost a battle, but we are still fighting a major war to preserve the freedom of physicians and patients alike. Remember the old saying: "United we stand, divided we fall." This statement has *never* been more true than now. We *must* unite!! We *need* teamwork!

This does not mean we must be against every form of medical legislation. Oh, I know some physicians are adamantly against any governmental involvement with medicine, yet I also know in some instances it would be important. For example, one form of legislation I think most would be for, is federal assistance to private carriers for patients with catastrophic illnesses. We know that life savings, homes, businesses, all could be wiped out by serious and prolonged sickness. Many of us know a friend, relative or patient who has suffered catastrophic illness and who needed assistance. I am certain we would be for such a program for assistance in this type of need.

But let *us*, as *professionals*, determine what programs, what evaluations, we need and what we want, and then determine what role the government should have, if any. Let's work together to amend and guide present and future legislation, and not just sit idly by while government works to administer our profession.

In summary, ladies and gentlemen, I decided that I could serve this Association best as your president by offering you four of what I hoped would be meaty ideas to chew on. I am convinced we must be sensitive to the inevitable changes of society, and therefore we must develop to meet its new needs. And I believe society needs, and we need, **First:** A Patient's Compensation Board, to drastically decrease the number and the abuse of malpractice suits. **Second:** The formation of a Medical Ethics Committee, to help our colleagues in a professional manner. **Third:** medical education in our schools, by developing a proposal and by requesting the State Board of Education to promote it. And **Fourth:** development of guidelines for our Board of Trustees, to aid them to amend and guide present and future legislation in order to keep medicine private and professional.

Our business, ladies and gentlemen, fellow physicians, is our patients, our public, our profession—in short, humanity. These four proposals might very well further our business, progress the Indiana State Medical Association and the medical profession. They require teamwork—your cooperation. I hope you consider them worthy of your consideration. Thank you.

Report of Mrs. Otis R. Bowen, President of the Woman's Auxiliary to the Indiana State Medical Association

HOUSE ACTION: Ordered filed.

Dr. Dukes, Dr. Wilhelmus, Trustees, Members and Guests of the Indiana State Medical Association. First, I must tell you that through our combined efforts in AMAERF we raised one million dollars this past year. The National Auxiliary Chairman called it our "Million Dollar Baby." Indiana received an award for the greatest increase over last year in total dollars and an award for contributors of $20 or more per capita. We feel the fine cooperation we had from the Medical Association helped us to attain these awards and we thank you.

We are continuing our interest in the Battered Child and are also concentrating on increasing our membership. Please go back to your counties and urge each one of your colleagues to get his wife out to meetings. I am sure she will be more helpful to you and to your community as a result of her activities in the Auxiliary. We are the best public relations people you have. The Auxiliary can give your wife information for your local community programs that is sound and good on a myriad of subjects.

This year we are cooperating in the Immunization Action Month and I would

like to present a Proclamation from the Governor to this House of Delegates proclaiming October as Immunization Action Month. The immunization levels against polio, for example, have dropped to a low of 60.4% in 1973 from a high of 84.1% in 1963. I have at the back of the room the 1972-73 school survey from the State Board of Health which shows the percentage in your county of all immunizations. Please take one and see if you can't raise the percentage of immunized children in your county. The State Board of Health through the local health officer has these vaccines without cost. Your Auxiliary stands ready to act as your staff and assist you, whether it be checking records of immunizations, calling parents, working through schools, day care centers, etc.

We have an interesting program planned for this convention and hope that you will participate in all the activities. If you miss me from Sunday on, it is because I must attend a National Auxiliary Conference in Chicago.

I have enjoyed working with your President, Dr. Dukes, and the other officers and trustees. This fall we have attended the largest District Meetings that we can remember. Dr. Wilhelmus, I am looking forward to working with you for the next six months.

My theme for the Auxiliary year has been "Together." In keeping with that I would like to close with the following:

A lovely, friendly word is WE:
Because it means both you and me,
We know the peace
which friendship lends,
We hold the faith between
two friends.
We part, and parting
makes us sad . . .
We meet, and then
the day is glad . . .
We know each other's hopes and fears,
We share each other's smiles and tears.
Friend of my own, comrade true,
The better part of "we" is *you.*

Report of Maria Ferraro, President, Indiana Chapter of the Student American Medical Association

HOUSE ACTION: Ordered filed.

The past year has been one of growth and development for the Indiana Chapter of the Student American Medical Association. Many programs previously in existence, such as MECO (Medical Education and Community Orientation), and interdisciplinary health team projects have involved more Indiana students than ever before in community medicine. Many new projects also came into being in the past year.

In March, the Indiana chapter was represented by two of the past officers and all the present officers at the national SAMA convention at Dallas. Being among the largest chapters, our representation in the House of Delegates was also among the largest, and we had more reference committee members than any other chapter. While the Indiana delegation was viewed as one of the most conservative groups, our views were respected, and we felt that we made a significant impact on the convention. A fuller report of convention activities was presented at the April meeting of the Indiana State Medical Association Board of Trustees meeting by Schuyler Geller, the immediate past president.

Many of the new programs which were initiated have begun to flourish. Several of them are student services, such as discount group buying, credit cards, short term loans, and free Student Directories. Some are community service projects, including the planning of a hypertension screening clinic and a venereal disease education program.

In the planning stages right now is a series of "brown bag" seminars which will deal with non-clinical aspects of medical practice, including malpractice insurance and suits, membership in professional organizations, national health insurance, PSRO, HMOs, and other topics geared to helping the student prepare for the problems he will face.

A project which will reach many often-forgotten students has been initiated recently. This is the Regional Campuses Committee. While the school has dealt effectively with these students at the Centers for Medical Education, they have been relatively ignored by the students at Indianapolis. SAMA hopes to help bridge this gap. While we encourage SAMA membership for students at regional centers, it is not a requirement for our services. We are in weekly communication with the regional campus students via newsletters included with the Student Council minutes. We will be sending groups of students (one SAMA officer, one Indianapolis freshman, and one student who was at the center the year before) to each of the centers three times through the school year. Hopefully, we will be able to increase communication between students at the various campuses and to help ease the transition from the centers to Indianapolis for these students.

On Sept. 30, 1974, a list of names was submitted in answer to an invitation by the Indiana State Medical Association to place students on several of your standing commissions and committees. In the interest of best representing the student body, there was no distinction made between SAMA members and non-members in selection of individuals. The entire student body was encouraged to apply and the appointments were approved by the Student Council. Upon checking after the student representatives were approved, it was discovered that 83% of these students are SAMA members. All the students who are going to be on your commissions are enthusiastic and willing to work hard. We believe they will serve you well.

The Student American Medical Association is attempting to fill whatever needs it finds among the medical students, and is, we believe, succeeding. More than anything else, SAMA is a means of becoming involved, and the Indiana SAMA chapter is helping to build conscientiously involved physicians.

Report of Joe M. Black, Chairman of Blue Shield Board of Directors

HOUSE ACTION: Ordered filed.

Presentation of Awards

Physician's Community Service Award —Henry W. Eggers, M.D., Munster.

Scientific Exhibit Awards

First Place—John P. Donohue, M.D., and Laurence J. Gott, M.D., Indianapolis

Second Place—Laird G. Jackson, M.D., and Associates, Philadelphia

Third Place—Eugene D. Van Hove, M.D., and Associates, Indianapolis

Award for Merritt O. Alcorn, M.D., Madison, for his many years of service with the State Board of Medical Registration and Examination of Indiana and to the Indiana State Medical Association.

The film "Federation Eavesdrop" was shown to the House.

Reports of Officers

Executive Secretary

HOUSE ACTION: Tabled.

In accordance with the directive of the House of Delegates and the Constitution and Bylaws, your secretary lists herewith the disposition of actions taken by the 1973 Meeting of the House of Delegates, Indiana State Medical Association.

The Printed Report of the President called for the review of the structure of the committees and commissions with the recommendation that it be referred to the Commission on Constitution and Bylaws, as well as the Commission on Special Activities, with an intent of a

joint meeting later to work out changes if this be their conclusion.

Action: This has been actively pursued by a subcommittee of the Special Activities Commission, under the chairmanship of Dr. Hovda of Evansville. The Commission has not yet finalized its report, nor met with the Commission on Constitution and Bylaws.

Report of the Executive Secretary. The continuing disparity between expenditures and receipts of the Annual Convention was referred to Future Planning Committee for study and solution.

Action: The Committee discussed the Annual Convention and the loss of funds from lack of interest by exhibitors. Dr. Haley pointed out that the Indiana Academy of Family Practice annually held a very successful meeting, and this was confirmed by Dr. Petrich. The idea was suggested that the IAFP and ISMA consider joining together for their state convention. It was pointed out that the IAFP separates its business sessions from the scientific meetings, and it was generally expressed that this was worthwhile. The Committee urged that contact be made with the Executive Secretary of the IAFP to get reactions to such a proposal, and this recommendation be brought before the Board of Trustees and the Commission on Convention Arrangements.

The President has discussed this with the secretary of the Academy of Family Physicians, and it was agreed that each would appoint a committee of three to discuss this matter. No decision has been made as of this time.

Report of 11th Trustee District: James A. Harshman, M.D., Trustee. The item on unequal distribution of primary care physicians as related to specialty and subspecialty physicians was referred to the Commission on Medical Education and Licensure.

Action: Dr. Beering pointed out that inasmuch as the Rural Health Committee of the Commission on Special Activities has established an assessment committee to assess the needs of rural areas, the action of the Commission should be to (a) recognize this effort on the part of the Commission on Special Activities, and (b) ask that this Trustee report be heard additionally by them. The committee took this by mutual consent. Further, Dr. Beering has referred the trustee report to the Department of Community Health Sciences of the I.U. School of Medicine. A copy of this portion of the minutes of this Commission was given to the Commission on Special Activities.

Resolutions:

73-1. Re declaration of non-participation policy. Adopted by the House and called for notifying the HEW officials that our membership be encouraged not to participate in PSRO activities. Such a communication has been sent.

73-2. Prevention of advertising in the media by all so-called members of the healing arts.

Action: This was referred to the Commission on Legislation, which drafted legislation but was unsuccessful in getting it through the last session of the General Assembly.

73-3. Calling for the establishment of an ISMA Section on Allergy.

Action: The House adopted this, and a change has been made in the Bylaws to carry this out.

73-4. Calling for a special reference committee. It was adopted by the House as amended.

Action: This resolution has been referred to the officers of the Association for their review and action.

73-5. Additional ISMA staff members. Adopted by the House and referred to the Board of Trustees for implementation for the monies to do so.

Action: A part-time director for this division has been selected and is currently at work.

73-7. House Staff Membership, which was adopted by the House as amended.

Action: This matter has been referred to the Board of Trustees, which established dues for membership, and to the Commission on Constitution and Bylaws for appropriate changes in the Constitution and Bylaws.

73-8. Annual Meeting of Educational Program. Adopted by the House.

Action: This has been referred to the Commission on Convention Arrangements, which has met with the Commission on Medical Education and Licensure, as well as other specialty groups who are planning the 1974 program.

73-10. Legislation to Define the Word "Physician." Adopted by the House.

Action: This was referred to the Commission on Legislation, which prepared legislation, but was not able to find a sponsor to carry this in the state legislature the past year.

73-11. House of Delegates Meetings. Referred by the House to Future Planning Committee.

Action: The Future Planning Committee voted to oppose the concept of two meetings a year. The motion was seconded and the motion passed and Dr. Glock then moved that, at the next meeting of the House, the delegation be polled with the recommendation that the ISMA continue with the regular fall meeting but that a poll be an opinion survey on a one-day meeting in the spring to consider urgent matters which have accumulated, legislative issues, new resolutions, etc. This motion was carried. It is assumed that this Committee will arrange to take such a poll at the 1974 meeting.

73-13. Prescription Labeling. Adopted as amended.

Action: This has been referred to the Commission on Legislation, and negotiations have been undertaken with the Pharmaceutical Association.

73-14. Correlation of Medicaid and Medicare Regulations and Provider Payments. Adopted by the House as amended.

Action: No action has been taken on this resolution as of this time.

73-15. Physician Advisors to the Indiana Society of the American Association of Medical Assistants. This was adopted by the House.

Action: This has been placed into effect. The American Association of Medical Assistants has named its advisors, and the Executive Committee has filled the one spot of the Indiana State Medical Association by naming Dr. Donald M. Kerr, Chairman of the Executive Committee, as our representative on their Advisory Committee.

73-16. Support of Indiana Academy of Family Physicians attempt to obtain funds through the state legislature for development of new family practice residency positions. The House adopted this and amended the report.

Action: This was referred to the Commission on Legislation, which worked with Indiana University officials on legislation in the recent session of the General Assembly.

73-17. Retirement Membership. The House adopted and amended the report for this to be voted on by the House at the 1974 Annual Meeting.

73-18. Creation of Section on Urology. Adopted by the House and such a section has been added to the Bylaws of the Association.

73-19. Opposing the Quality Assurance Program for Medical Care in the Hospital as Proposed by the American Hospital Association. This was adopted by the House with recommendation that the Public Information Commission give adequate publicity as to why this program is opposed and so it will not be construed as against good quality of care.

Action: No action has been taken on this resolution by the Commission on Public Information at this time.

73-20. Concerning State Highway Commission. Adopted as amended. Referred to Commission on Emergency

Medical Services for their study with the recommendation that consideration be given the suggestion that a physician serve in an advisory capacity on the State Highway Commission.

Action: The Commission discussed Resolution 73-20 recommending that a physician serve in an advisory capacity on the State Highway Commission. They endorsed the concept but took no action on the matter.

73-21. Subject—Involvement in PSRO. Adopted by the House as amended. The Resolution called for an alternative of means of Peer Review and Quality Control without government control, and permitted the Indiana State Medical Association to establish an independent corporation. This was referred to the Board of Trustees.

Action: The Board of Trustees authorized the President to appoint a committee to begin work in establishing such an organization, and Dr. Dukes appointed Dr. Peter R. Petrich of Attica, as chairman, Dr. Dukes, Dr. Wilhelmus and Dr. Santare as the other members of the committee. The Board of Trustees at the June meeting had the presentation of the proposed articles of incorporation. However, that has not been finalized as of this date.

73-22. Establishment of a For-Profit Corporation on Malpractice Insurance. Adopted by the House of Delegates.

Action: This was referred to the Board of Trustees, which, in consultation with the Commission on Medical Economics and Insurance, and with the Harland organization, decided the first thing to be done was to make a survey of the membership to see if there was sufficient interest to warrant proceeding with this program.

The survey has been made and will be reported to the House of Delegates. A committee has been established with Dr. Donald M. Kerr of Bedford as chairman, the balance of the committee consisting of Dr. Dukes, Dr. Wilhelmus and Dr. Santare for the purpose of drawing up articles of incorporation for this project.

75-23. Increase in Dues. Adopted by the House as amended, which increased the dues of the Association 10.00 per year as of January 1, 1974, for use of the Commission on Public Information.

This concludes the report of the actions taken by the House and what actions have been taken on these referrals.

MEMBERSHIP REPORT:

Membership Records are Being Shattered

Is it the feeling of unity that is beginning to have its effect? Is it the Indiana Education Program? In any event, membership growth in both the ISMA and AMA for the first six months of 1974 has broken all records while the number of ISMA members not joining the AMA has shown a slight decrease over the last two years. We still need to find some way to get 327 ISMA members to reassess their reasons for not joining the AMA.

ANALYSIS OF MEMBERSHIP
TREND OVER PAST 10 YEARS

Year	ISMA 7/31	Gain Loss	AMA 7/31	Gain Loss	ISMA Members Non-AMA Members
1965	4356	+25	4255	+30	101
1966	4367	−11	4254	− 1	113
1967	4356	−11	4180	−26	176
1968	4400	+44	4246	+66	154
1969	4450	+50	4301	+55	149
1970	4457	+ 7	4291	−10	166
1971	4489	+32	4236	−55	253
1972	4526	+37	4179	−57	347
1973	4625	+99	4292	+113	333
1974	4743	+118	4416	+124	327

CHAMPUS:

For the period from October 1, 1973, to June 30, 1974, the CHAMPUS Department has processed and paid 15,545 claims, with a total dollar value of $1,311,604.84.

The CHAMPUS Department is again commended by the Department of Defense for its splendid work and the fact that their backlog of claims is lower than the national average, and lower than the goal of the Defense Department. The Indiana program is averaging about between four and five days backlog on claims.

We have been summoned to a meeting in Denver in September to have explained to us the changes which will take place in the CHAMPUS program in the next few months. It seems as though at the present time, from the information that we have, that many of the services, previously offered under CHAMPUS will be discontinued or drastically curtailed.

TEL-MED:

The success of the Tel-Med program is almost unbelievable. Letters are being received daily from people throughout the state of Indiana praising the physicians for making this service available to them. With the program beginning in March of 1973 and ending in May of 1974, with only one unit receiving local calls, a total of 70,845 tapes were played. We began the statewide system on May 22, 1974, in which we now have ten WATS lines available free of charge to people throughout the state of Indiana, and 10 local lines to the Indianapolis free calling area. For the period of 33 days from May 22 to June 29, the local lines have recorded 10,535 tapes played, the WATS line has recorded 19,210, for a total for both units for this short period of 33 days of 29,745 tapes which have been listened to by your patients. The total of the entire program, from March 1973 up through June 29, 1974, shows that we have played a total of 100,590 tapes for the people of the state of Indiana.

Our average calls per day are now running 901, with the largest single day we had totaling 1,097 calls. From the letters and cards received, I believe the Association should really consider this one of their best public relations programs in the past several years.

USE OF THE BUILDING:

The use of the building is not decreasing, but rather increasing as time goes on. The building is normally having meetings during the week, as well as on weekends.

Currently, the building is at capacity usage with the current staff and space for necessary mechanical equipment to conduct the affairs of the Association.

At the present time employees are practically sitting on each others' laps, and the aisleways of the offices are full of supplies and materials which have to be stored before being sent out to the membership of the Association.

The Board and the Building Committee have under study plans for possible expansion of the building, and I am sure there will be a report made to the House by the Board and by the Building Committee for their consideration.

ACTIVITIES OF THE VARIOUS COMMITTEES AND COMMISSIONS:

I will not attempt to detail the activities of the various committees and commissions of the Association, as these matters have been published in THE JOURNAL and widely distributed for information of the county society officers.

The activities of these groups are covered in their annual reports to the House, and I would urge you to read them to familiarize yourself with the activities that have been taking place during the past year. The commissions and committees have been unusually active, and I believe they have produced some good recommendations for consideration by the Association.

WHAT'S AHEAD?

Plans are under way, of course, to establish a not-for-profit corporation to do Peer Review and Quality Control, without government interference. This activity and the activity of PSRO in this state is going to be a major problem, in

my opinion, for the Association in the coming months and year. With the action of the House of Delegates urging our members not to participate in PSRO activities, and with the feeling of the House that we should establish an independent organization, plans are proceeding to develop this particular type of corporation, which is going to be expensive in development and operation. Dr. Petrich, a past president of the Association, is chairing the committee to set this up, and I am sure will have some report and recommendation for the House of Delegates to consider at this particular meeting.

A for-profit corporation for malpractice insurance is fast becoming a reality. A survey has been conducted by the Commission on Medical Economics to determine the interest of the membership of the Association getting into this activity. The poll has produced thousands of cards, which have not been tabulated, but it is hoped to have them tabulated and a definite program ready for offering to the House at this meeting.

The plan copied after that of Florida, if successful here as it apparently is in Florida, should be a great boon to the Association. We are informed that the first year of operation of the Florida plan produced a profit to the Florida Medical Association of some $100,000. If this could come to realization in the state of Indiana, it would certainly help conduct the affairs of the Association without additional increase in dues.

In the coming months and years, the legislative activity is bound to increase, and probably litigation also will increase, necessitating a good staff of legal counsel and headquarters staff to handle these particular problems.

The Continuing Education program is off to a good start, and it looks like it will be a very successful program for the Association. It is evident that, if the program continues to grow, the operation of it will require the full time services of a Continuing Education Director.

Inflation has hit your Association the same as it has in your personal practice, and your private lives. The finance committee of the Board of Trustees has undertaken at the time of this writing, a study of the financial position.

I express my appreciation to the staff for their loyalty and dedication to their responsibilities during the past year, and to the various Committees and Commissions, Executive Committee, and the Board of Trustees for their helpfulness and understanding of the problems facing this Association.

Your Headquarters Office is established to serve you and to look after your interests, and we welcome any suggestions from any member at any time we can be of service to you.

JAMES A. WAGGENER,
Executive Secretary

Treasurer

HOUSE ACTION: Ordered filed.

The audit for the fiscal year ended September 30, 1973, was published in detial in the January 1974 *Journal*. Inasmuch as the current fiscal year ends September 30, 1974, the audit will not be available for presentation to the

INDIANA STATE MEDICAL ASSOCIATION
Statement of Financial Condition

ASSETS	6/30/74	9/30/73
GENERAL FUND:		
Cash on deposit	$ 81,871.34	$ 87,522.85
Investments—at cost:		
U.S. Treasury Bonds—long term	55,167.37	55,167.37
U.S. Treasury Bills—short term	300,573.94	179,829.30
Mutual Fund shares	31,799.78	31,038.50
Accounts receivable:		
Federal Grants	33,894.65	7,038.46
Other	14,479.10	17,961.24
Prepaid expense	14,093.58	12,070.72
Office furniture and equipment—net of accumulated depreciation	17,393.85	19,845.68
	549,273.61	410,474.12
BUILDING FUND:		
Cash on deposit	4,635.72	4,142.28
Cash in savings account	7,121.03	6,937.74
U.S. Treasury Bills	189,419.93	159,857.92
Prepaid expense	1,365.49	865.88
Accounts receivable	1,425.01	—
Headquarters property		
Land	69,187.60	69,187.60
Office building and improvements—net of accumulated depreciation	246,471.39	252,769.54
Rental properties—net of accumulated depreciation	77,396.52	78,829.32
	597,022.69	572,590.28
STUDENT LOAN FUND:		
Cash in savings account	19,190.00	19,190.00
Certificates of deposit	20,810.00	20,810.00
	40,000.00	40,000.00
MEDICAL DEFENSE FUND:		
Cash on deposit	930.60	807.60
Cash in savings account	23,826.36	22,021.46
U.S. Treasury Bonds—long term	25,526.53	25,323.40
Accounts receivable from General Fund	720.15	—
	51,003.64	48,152.46
	$1,237,299.94	$1,071,216.86

LIABILITIES AND FUND BALANCES

GENERAL FUND:		
Accounts payable	$ 18,978.95	$ 5,347.47
Payroll taxes withheld	—	1,689.34
Accrued taxes	—	308.21
Due to Medical Defense Fund	720.15	—
Dues payable to AMERF	20,420.00	20,407.50
Advances from AMA	9,277.81	9,277.81
Unearned portion of current year dues	215,572.50	107,692.13
Dues restricted to Speaker's Bureau	40.840.00	—
Exhibitors' deposits for annual meeting	365.00	13,920.00
Fund Balance	243,099.20	251,831.66
	549,273.61	410,474.12
BUILDING FUND:		
Accrued taxes on rental properties	3,324.97	2,857.43
Damage deposits and accounts payable	706.25	706.25
Loans from Members (non-interest bearing)	20.325.00	20.825.00
Fund balance	572,666.47	548,201.60
	597,022.69	572,590.28
STUDENT LOAN FUND:		
Fund balance	40.000.00	40,000.00
	40.000.00	40.000.00
MEDICAL DEFENSE FUND:		
Fund Balance	51,003.64	48,152.46
	51,003.64	48,152.46
	$1,237,299.94	$1,071,216.86

House at this time. A current, detailed financial statement will be prepared by the Association bookkeeper and made available to the reference committee prior to the October meeting.

The accompanying report is a Statement of Financial Condition as of June 30, 1974, compared to the audited financial statement of September 30, 1973, as published in the January 1974 *Journal*.

HUGH K. THATCHER, JR., M.D.
Treasurer

Chairman of the Board

HOUSE ACTION: Ordered Filed.

During the past year the Board of Trustees met several times to discuss a multitude of matters. The volume of business of the Board has currently reached such proportions that it is now routine for the Board to meet both on Saturday evenings and all day on Sundays to discuss each subject in proper detail and in depth.

During the year the complete minutes of each trustee meeting were printed in THE JOURNAL of the Indiana State Medical Association, and a highlight summary of each meeting was sent to presidents and secretaries of county medical societies, ISMA delegates and alternate delegates, AMA delegates and alternate delegates, and executive secretaries of county medical societies.

However, for the purpose of this report I will summarize briefly for the membership some of the actions of the Board during this past year. This does not constitute a complete summary of the numerous speakers who appeared before us to relate matters of concern to our members or a complete listing of all of the actions of the Board.

The Future Planning Committee was asked to study and report back on the Allen County Medical Society's proposal for changing meetings of the House of Delegates to more effectively coordinate activities of the Association with legislative programs. Locations for future conventions of the Association as currently projected are 1974—Indianapolis; 1975—French Lick; 1976 and 1977—Indianapolis; and 1978—French Lick.

The membership dues for students was given consideration by the Board as an outgrowth of House of Delegates' action to grant memberships to students. The Board referred the matter to the Commission on Constitution and Bylaws with the request that they consider such dues and report back to the Board. Since this action is a constitutional one, final action on the matter is to be taken at this (1974) meeting of the House.

The new Medical Practice Act and its introduction into 1974 legislature received lengthy discussion. Final outcome of the pro and con discussion was that the legislation will not be introduced this year but that an amendment to the current Act be introduced to give the Board of Medical Registration and Examination the power to suspend a physician's license pending review by the courts. Board felt that there was too much strong opposition to the new Medical Practice Act by physicians to proceed with the introduction of the Act at this time. It was also expressed that time for presentation of the legislation in 1974 was too limited and that it should be revised for presentation in 1975.

The continuing education accreditation program received up to $10,000 to conduct this program. The Board asked the chairman of the Commission on Medical Education and Licensure to appear to explain specifically how the money would be utilized through the addition of a staff person to oversee this program.

A proposed emergency medical services bill was reviewed by the Board and was referred to the Commission on Legislation for implementation through the legislature.

Family Practice residency programs for Indiana were also reviewed and recommendation was made that a bill be introduced by the Commission on Legislation concerning development of such programs.

In other actions dealing with legislative matters, the introduction of a "Death with Dignity" bill was moved but was not introduced because of the lack of a second to the motion. Last year's attempt to introduce a similar bill met with no action because legislators did not want to sponsor such a bill.

The rejection of QAP and TAP programs called for in a resolution was adopted by the Board. ISMA delegates to the AMA were instructed to introduce a resolution to the AMA House of Delegates at Anaheim. The resolution stated that quality of care is the proper func-

tion of the physician through his medical society and hospital staff and that the two programs involve great expense and non-physician review. QAP is the Quality Assurance Program of the American Hospital Association. TAP is the Trustee-Administrator-Physician Program of the Joint Commission on Accreditation.

In response to the PSRO resolution adopted by the House of Delegates, the Board considered the following questions on establishing an independent corporation to accomplish peer review and quality control in medical care: what type of organization should be established; what will its function be and how will it be funded? After lengthy discussion, the Board adopted a motion to proceed with the organization of a non-profit corporation with the advice of the legal counsel of ISMA.

Members of the Board were asked to contact Congressmen personally on objections to PSRO and stand of ISMA. The Board also passed a motion that a letter be sent to every Indiana Congressman advising them of ISMA action on PSRO with a note that they would be contacted by a trustee.

A policy of no contracts with proprietary hospitals by Blue Cross was asked to be withdrawn by the ISMA Board of Trustees. In a resolution, the Board pointed out that more and more communities are finding themselves in a "position where it is impossible, because of present tax burdens to make the necessary improvements or replacements as required by the State Board of Health and that one of the most pressing needs in Indiana is to improve the quality of medical care in smaller communities, and the best way to do it is to improve facilities so that new doctors will be attracted to those communities." The resolution asks that proprietary hospital plans and development in communities be judged on individual merit by Blue Cross.

The establishment of a for-profit corporation to set up a professional liability program for members of the ISMA was given the go-ahead by the Board. In addition, a survey will be made of the membership to determine interest of members in the program. Investigation by the Commission on Medical Economics and Insurance through the past year has shown such programs are working to the benefit of the association and its membership. The corporate bylaws will be reported back to the Board for approval before additional procedures take place. Board authorized up to $1,000 to accomplish these preparatory steps.

Plans went on the drawing board for expansion of the ISMA headquarters by action of the Board. Week-long use of the building by the membership and allied health and medical groups, lack of parking space, lack of necessary office space, lack of storage space and anticipation of future needs for the Association are some of the reasons for expansion plans. Potentiality of holding House of Delegates' meetings in the new headquarters is a real possibility with accompanying lesser costs. Board authorized up to $15,000 for architectural fees, drawings, etc.

The Joint Practice Committee of Nurses and Physicians was granted $1,000 by the Board in a one-time grant to initiate activity of the committee. The Board heard Dr. G. J. Rosenberg report on the planned activity of the committee which is concerned with the congruent roles of nurses and physicians in new patterns of medical practice. The Indiana Nurses Association has also allocated $1,000 to the joint committee. Forty-six states now have such committees. The physician-members are to be nominated by the ISMA and their policies are to be approved by both organizations.

The creation of an independent state university from the regional campus of Indiana-Purdue University, Indianapolis, was discussed at length. Motion was made and passed that the Board go on record opposing the Indiana University School of Medicine being a part of the new university and that legislators be so advised. The board further moved to send a letter to personal physicians of the legislators requesting them to contact their legislators.

Physicians were queried by health insurance carriers as to their medical judgment in utilizing types of injections for patients under Medicare. Specifically referred to was the use of B-12. The Board recommended that a letter be sent to the carriers objecting to clerks not only questioning but recommending treatment. Also discussed was the activity of the State Department of Public Welfare requesting physicians to submit plans for certain types of elective surgery to gain permission to operate. The Board voted that the language in the letter was totally unacceptable to the ISMA and that the Board's displeasure be conveyed to Blue Shield, the State Department of Public Welfare, and to The Travelers Insurance Company.

The promotion of a standard claim form for all health insurers was passed by the Board, and the Indiana Insurance Commissioner was approached on this matter.

Director of the Joint Commission on Accreditation of Hospitals, Dr. John D. Porterfield, reported to the Board on the commission's activities. The invitation came from Indiana because of commission inspectors leaving the impression that retrospective audit of physicians was to become mandatory and expected by the commission if a hospital was to be accredited. Dr. Porterfield clarified this for the Board and answered a multitude of questions concerning the commission's operation. He explained the history of the joint commission and the objective of the commission to develop standards and programs which would encourage medical staffs to be more involved in the quality of their work.

The rural assessment and assistance program formulated by the Commission on Special Activities was authorized by the Board to continue its progress and to seek funds from the Department of HEW. The major objective is to develop a suitable group of practicing physicians, physicians in training, other health providers and interested citizens, with an interest and experience in rural areas, to provide assessment and assistance in obtaining physicians, other medical personnel, and facilities for identified medically underserved areas.

Dr. Steven C. Beering, new dean of the I. U. School of Medicine and chairman of the ISMA Commission on Medical Education and Licensure, introduced Mr. Edward Raffensperger, new coordinator for the ISMA continuing medical education accreditation program. The dean pointed out to the Board that Memorial Hospital and St. Joseph's Hospital in South Bend; Deaconess Hospital, Evansville; St. Joseph's Memorial Hospital, Kokomo, and Reid Memorial Hospital, Richmond, have been accredited, with the LaPorte Hospital, LaPorte, currently being considered.

Tel-Med, the ISMA telephone health information service, was expanded to the entire state through an additional grant from Regional Medical Programs, a major contributor along with Eli Lilly and Company.

Comprehensive Health plans to fund a position in ISMA of a liaison representative to state and regional CHPs if the current program is extended and funded, Dr. Paynter, Commissioner of Health, reported.

A committee of the Special Activities Commission is making a study and evaluating the structure and activities of the committees and commissions of the ISMA. The Commission's recommendations will be forthcoming to the Board.

Copy and costs for a new insurance pamphlet entitled "You and Health Insurance" was presented to the Board by Dr. Kenneth J. Ahler, author of the pamphlet and member of the Commission on Public Information. The pamphlet gives the physician's viewpoint on health insurance and would be distributed to patients in doctors' waiting rooms. The Board approved the printing and distribution.

Referring to PSRO organizations across the nation as a "mixed bag," Dr. Donald Wood, AMA trustee, told the Board that the national board had taken a lot of criticism. At the moment, he said, there is a great surge for repeal. He cited, however, several states which were pro-repeal but while pushing for repeal were also seeking federal funds to establish a PSRO. AMA is in a dif-

ficult position as this type of bilateral action occurs, he said. The AMA House of Delegates, he said, would have to make a clear-cut policy.

The establishment of a PSRO support center by the ISMA was then discussed at length and the motion was made to apply for the center. The motion lost by a vote of nine to eight, a margin of one.

The establishment of a malpractice insurance program was reported to the Board. Florida representatives met with Dr. K. O. Neumann, chairman of the Commission on Medical Economics and Insurance, and planned a questionnaire to determine the interest of Indiana physicians. The Board moved that the survey be approved.

"Maintain the 55-mile-per-hour speed limit in Indiana," the Board stated in a motion, which passed. Observation was made that the lower speed limit had saved many lives and that even though the fuel shortage crisis had passed, the limit should continue because of the marked decrease in the highway toll.

Concerning the repeal of PSRO, the Board mandated the AMA delegation to work for and use its skill and resources to repeal PSRO and that a resolution be submitted asking for the AMA to take a positive stand for repeal.

The American Medical Association was urged by the Board to develop graphs, charts and other materials to illustrate the rise in physicians' fees in comparison with those of other professions.

Following the discussion of the Medical-Legal Defense Fund, the Board moved that monies collected in the fund be held and permitted to grow with eventual use in supporting legislation to change the existing Indiana laws concerning malpractice, and that the fund allow consultation between a physician and his attorney and the ISMA's legal counsel on questions not pertinent to malpractice defense and with the approval of the Executive Committee. The motion was based on a recommendation by the Medical-Legal Review Committee and will be forwarded to the House of Delegates for their consideration.

Feasibility of the Indiana Academy of Family Practice and the ISMA joining together in an annual convention was discussed by the Board. The Board moved to have three members of the Board meet with three members of the Academy Board to discuss possibilities.

A form issued by Mutual Hospital Insurance, Inc. and Mutual Medical Insurance, to be signed by the patient for authorization of disclosure and use of information in patient records and other similar forms, was discussed by the Board. The Board passed a motion directing the ISMA legal counsel to explore the advisability of instituting a suit against the intermediaries and continue to take action to stop the wholesale invasion of medical records in government programs.

The Statute of Limitations in Lake County malpractice suit was discussed by the Board. Lake County physicians were sued by a man who stated he had been injured at birth in the course of delivery. He filed suit just before his twenty-fourth birthday. The case was settled in the physicians' favor in Court of Appeals and overturned by the Supreme Court. The Board moved that legislation be drafted by ISMA attorneys to offset such future suits.

The Board heard a report that the physicians' assistants and nurse practitioners are a reality in Indiana. A proposed resolution to the House would include the following: (1) that they be graduates of certified programs, (2) that only one certified graduate be allowed to work for a doctor, (3) that they be under the direct supervision of a physician and all of this pertaining to medicine, (4) that they be allowed to work in the hospitals but will not be permitted to write orders for treatment to be made, unless countersigned by the doctor within 24 hours. The Board moved to forward the resolution to the House of Delegates.

Concerning the building program, the Board at its June meeting passed a motion to proceed with blueprint development for an additional 16,000 square feet of space and an alternative plan for 10,000 square feet, that contractual bids for the construction be taken and presented to the August meeting of the Board and then the final plan presented to the House of Delegates.

Progress of the Speakers' Bureau was reported to the Board. The speakers are to be handled by a special service which will book the speakers, evaluate audience reaction, handle publicity and all other details.

The Board is now reviewing the articles of incorporation of the Indiana Medical Education and Developmental Information Center, corporate name for the independent peer review organization, directed to be developed by the House of Delegates in 1973.

VINCENT J. SANTARE, M.D.
Chairman

Supplemental Report of the Chairman of the Board of Trustees

HOUSE ACTION: In reviewing the Supplemental Report the Reference Committee recommended the deferment of Resolution No. 74-28, pending the report of Reference Committee No. 4. Committee recommended adoption of Resolutions No. 74-29, 74-30 and 74-31. The Reference Committee recommended adoption of its report concerning I-MEDIC; that implementation be delayed because of conflicts it may generate. Reference Committee recommendation was amended as follows: "The Reference Committee also reviewed the report of the Board concerning I-MEDIC which is a corporation proposed for the purpose of statewide Peer Review as a substitute for PSRO as mandated by the 1973 House of Delegates, again only at the request of the local reviewing body."

The Board met yesterday, Oct. 3, 1974, from 6:00 p.m. to 12:30 a.m. (in the morning). The Board Subcommittee on Fiscal Matters made a report, and a budget was submitted by the Executive Committee. There were many budget items which the Board was unable to proficiently deliberate and designated them for presentation as a resolution for a dues increase. The Board's determination after consideration last night was that all the items representing the cause for dues increase be presented to the House and after reference committee deliberation for the House to act on the items individually.

(1) **Commissions**—The 1974 budget was $50,335. The 1975 projected budget cost is $145,600. This major increase is for the operation of the statewide Tel-Med program for a full year at cost of $110,000. In the past, this program has been funded by grants from Eli Lilly and Company and from the Indiana Regional Medical Programs. The RMP informs us that additional grants in the future may not be forthcoming. We are seeking other sources of financing, but we should budget the cost to the Association in case other sources of financial assistance are not found. The cost per member would amount to $26.63, based on current membership.

Last year this House of Delegates voted a $10.00 per member increase in dues for two years. This money was earmarked for the Commission on Public Information to establish a Speakers Bureau. After one year of operation the money earmarked from the 1973-1974 dues has not been used. The Board asks that the House consider utilizing this money for the Tel-Med grant.

(2) **Officers and Board**—The 1974 budget was $51,520. The projected budget for 1975 is $61,350. The $10,000 increase was necessitated by increased expenses of your officers, the AMA meetings, and the Board meetings. This amounts to approximately $3.00 per member.

(3) **Administrative Expenses**—The 1974 budget was $256,160. The 1975 projected budget is $313,266. Primarily, the increases are necessitated by the following:

(a) Cost-of-living salary increase for ISMA employees;
(b) Employment of additional personnel, which was mandated by the 1973 House of Delegates;
(c) The result of inflation on our other expenses.

Your increased cost amounts to $14.00 per member.

(4) A not-for-profit corporation for peer review on a statewide basis was authorized by the 1974 House of Delegates. There was no fiscal note attached to the resolution last year. The Board has appointed a committee which has set up a corporation called I-MEDIC for the purpose of statewide peer review and as a substitute for PSRO. The estimated cost of proceeding with this course is about $20,000—which would be about $4.00 per member. We have an opinion from our legal firm which should be presented to the reference committee in consideration of this budget item.

(5) *The Journal—The Journal* is budgeted purposely for a loss as, under federal and state tax laws, a profit would subject us to taxation. Six dollars ($6.00) of each member's dues are paid to *The Journal* so the general fund subsidizes the loss. *The Journal's* expenses are increasing due to inflationary costs of paper and production. Yet the cost of publishing our journal is the lowest of all the journals that are members of the State Medical Journal Advertising Bureau. The budgeted loss on *The Journal,* which is an accounting item, amounts to $10.00 per member.

The Board would remind the delegates that, in order to satisfy our advertising contracts, the issues of *The Journal* cannot be reduced; however, if it is desired, the grade of paper used in *The Journal* can be reduced.

These items are being presented to the House, and I move they be sent to a reference committee to be submitted as individual resolutions to the House for action.

VINCENT J. SANTARE, M.D.
Chairman

First Trustee District

HOUSE ACTION: Ordered filed.



BERNARD B. ROSENBLATT, M.D.
Trustee

The First District Medical Society held its annual meeting on May 9, 1974, at the Rolling Hills Country Club, Evansville, which was well attended by physicians and their wives from throughout the district. Mead Johnson and Company hosted the social hour, and Mr. Tom Miller, new field service representative for Mead Johnson and Company, was introduced.

Other guests in attendance included Joe Dukes, M.D., president of ISMA, and Mr. Gary Miller, director of professional relations for Indiana Blue Shield.

Speaker for the evening was Mr. Wayne Bradley, assistant director of the Washington office of the American Medical Association. Mr. Bradley gave an extensive and extremely interesting report on the current state of federal legislation in the area of health care. He particularly emphasized those areas in which organized medicine has achieved success in recent months, including the successful attempt to fight pre-admission certification, the prevention of continuation of fee controls, the recent HEW decision that physician offices and clinics are not to be included in the national certificate-of-need legislation (Section 1122 of Public Law 92-603), and the recent upgrading of the Keogh Plan. Mr. Bradley mentioned that several polls show that the public does not currently give high priority to national health insurance.

Dr. Dukes brought greetings to the First District from the ISMA and reviewed state action in regard to PSRO. He stated that some of the concerns of the Board of Trustees are that PSRO will infringe on the patient's rights, create a loss of confidentiality and threaten individuality of treatment. In addition, he said that the program would create a bureaucracy and would duplicate existing peer review programs. He said, however, that there would be a state support center in Indiana developed by people close to medicine, and this group would act as a watchdog.

Because he had only recently joined the Blue Shield Board, Dr. Ralph Carlson asked Dr. Willard Barnhart, last previous Blue Shield Board member from the First District, to report on the current status of Indiana Blue Shield. Dr. Barnhart reported that Indiana Blue Shield is 8th in the nation in the amount of business transacted, and covers two million people. Unlike many other plans, Indiana Blue Shield has a sizeable financial reserve. In 1972 and again in 1973, utilization leveled off, and a rebate in the amount of $11 million the first year and $19 million in the second year was made to members. Blue Shield is presently returning 94 cents of each dollar of premium payment, which means that only 6 cents per premium dollar is spent for administration. Dr. Barnhart mentioned that this summer Blue Shield will offer an improved indemnity plan. These will be less costly than usual and customary contracts, and will range from 60 to 90% of the cost of usual and customary policies. He asked that physicians urge their patients to participate in Blue Shield plans.

Dr. William Dye, First District President, presided over elections of officers, and the following persons were elected: Albert S. Ritz, M.D., president; Martin Bender, M.D., vice president; John Barrow, M.D., secretary-treasurer; Bernard B. Rosenblatt, M.D., trustee; DeVerre Gourieux, M.D., alternate trustee.

During the past year, the First District supported a reception and luncheon for ISMA officers, trustees, delegates and alternate delegates in honor of Gilbert Wilhelmus, M.D., candidate for president-elect of ISMA, and P.J.V. Corcoran, M.D., candidate for delegate to AMA. Both candidates were subsequently elected.

In order to maintain close liaison with the only staffed county medical society in the First District, the trustee is routinely invited to attend meetings of the Vanderburgh County Medical Society Board of Directors. Here, he reports on activities at the state level, and receives suggestions and information to take to the ISMA Board of Trustees. This arrangement has worked well for several years.

Among other actions originating in Vanderburgh County but of significance to the entire district this past year are:

1. A resolution calling for redefinition of the legal meaning of the term "physician" was sent to the House of Delegates, approved, and an attempt was made to seek state legislation embodying this change. The attempt failed, but will be repeated in the coming year.

2. The society has very nearly completed the updating of fee guidelines for all specialties for the purpose of guiding peer review.

3. A society membership roster which will include all First District physicians will be published in September 1974.

4. A standard health and accident insurance form was approved in Vanderburgh County and sent to the ISMA Board of Trustees with the suggestion that ISMA seek its approval by the State Insurance Commission. The matter is presently being considered by the Commission.

5. The Vanderburgh County Medical Society is cooperating with the three Evansville hospitals and the Area Health Planning Council in presentation of community health education forums each month during the fall and winter. These are on various disease entities, and the first two, on allergies and diabetes, were extremely well attended and well received.

6. At the request of the Area Health Planning Council, the Vanderburgh County Medical Society is evaluating the functioning of the new open heart surgical unit at Deaconess Hospital.

7. Area physicians cooperated with the Evansville Mayor's Energy Action Committee in preparing an estimate of the energy needs of the health care sector of the community.

8. The county medical society joined the First District in hosting a reception and luncheon to support the candidacies of Gilbert M. Wilhelmus, M.D. for

ISMA president-elect and P.J.V. Corcoran, M.D. for AMA delegate.

9. The county society arranged for seven area physicians to appear on television in connection with various health programs.

It is rewarding to the trustee to see the high degree of cooperation among physicians throughout the First District and the leadership which our members show in so many areas. He wishes to thank them for their active participation and also for their support during the past year.

BERNARD B. ROSENBLATT, M.D.
Trustee

Second Trustee District

HOUSE ACTION: Ordered filed.



PAUL W. HOLTZMAN, M.D.
Trustee

During the past year, true representation of my district has become even more exasperating for I find the district divided in its goals and divided in its opinion of the ISMA and the AMA. It is difficult to be positive in my report, but there have been the usual poorly attended medical society and district meetings.

Progress made by the ISMA and the AMA is frequently overlooked. Criticism among the members comes easily, but constructive help is not offered. Our association is being divided by those who favor or oppose government interference. Those new to medicine entertain new philosophies concerning "the place of medicine" and further divide us. I have asked my own society, without avail, to introduce a resolution to the House of Delegates to allow the dues of ISMA to be increased in order that we could have more field representation and thus disseminate information more readily to practicing physicians. I find information regarding concepts, goals, and intentions of the ISMA and AMA widely misunderstood or poorly interpreted.

I believe our goal during the next year, should be directed toward union and somehow—someway—allowing all physicians in the state to know and understand the basic problems of medicine before they preform opinions and decisions not based on sound information.

Most of us physicians treat our ISMA like our investments—we ignore them, but raise hell when they fail to yield good results.

PAUL W. HOLTZMAN, M.D.
Trustee

Third Trustee District

HOUSE ACTION: Ordered filed.



ELI GOODMAN, M.D.
Trustee

The 1973 Annual Meeting of the Third District Medical Society was a combined meeting with Third District of the Indiana Academy of Family Practice.

The meeting was held at the Marriott Resort Center in Clarksville on Wednesday, Sept. 26, 1973. A good-sized delegation to represent the State Medical Association was headed by Dr. James Gosman, president.

District president, Dr. Claude J. Meyer, presided, and Dr. Robert K. McKecknie served as secretary.

Dr. Gosman gave a comprehensive and thorough report from his position as state association president. Dr. John Paris, district representative and vice president of Blue Shield, gave a report on the current relationship between Blue Cross and Blue Shield, and answered a number of questions from the floor.

Reports were made by the trustee and the alternate trustee. Much discussion took place about the apparent failure of Indiana AMA delegation to make our position of opposition to participation in PSRO-type activity perfectly clear at the AMA level. It was decided to bring this matter to the attention of the House of Delegates of the Indiana State Medical Association at its annual meeting in October 1973.

In other business, a resolution to increase district dues to $10 was unanimously passed. In election of officers, Dr. Claude J. Meyer was reelected District Chairman; Dr. Robert K. McKecknie was named District Secretary, and Dr. Eli Goodman was reelected District Trustee.

The after-dinner speaker was Dr. Pillows of the Eli Lilly Company. His topic was his work with youth and the drug program.

The 1974 annual meeting will be something new for the Third District in the form of a weekend to include lots of fun. Golf, tennis, swimming, boating and dancing are all on the agenda, along with three hours course credit by the Academy of Family Physicians.

This combined District ISMA-IAFP meeting will run from 1:00 p.m. Saturday, Sept. 14 through 1:00 p.m. Sunday, Sept. 15. It will be held at the fabulous Marriott Inn-Sports Center at Clarksville, where a floating bridal suite is available to young (or not so young) vigorous lovers at only $49 a day.

The scientific program "What Do You Say After You Say Hello?" will be of equal interest to the wives as well as the doctors. Dr. and Mrs. Edgar Stuntz of Purdue will give this Wyeth Laboratory-sponsored program beginning at 3:00 p.m. Saturday afternoon.

There will be a dinner dance Saturday evening. A bloody-mary brunch on Sunday morning will be sponsored by Bonco Laboratory and informal discussions, swimming and other sports will round out the Sunday program.

Really, all I can say about this exciting program is "Y'all come."

I would like to conclude this so-far factual narrative annual report with some personal observations of great concern to me.

In my last report (1973) I indicated my great concern about the impact of PSRO on the nature of medical care of American people and on the effectiveness and life position of each and every physician along with it.

Since that time, as you all know, the ISMA has taken an official position opposed to PSRO and since I was present I can personally vouch that our AMA delegation reflected this position in their voting at the June 1974 AMA meeting in Chicago. However, as you all know by now, our position was not adopted and the AMA will try to make PSRO work while not consulting those individual states that elect to take different steps from this now official AMA policy.

I have always felt that the structure of the AMA is indeed democratic and we have heard the will of the majority and in our system we must abide by it.

I would, however, fault that House of Delegates of the AMA for one thing in the brief consideration of this vital issue of PSRO. There was an appeal for a roll-call vote which the House quickly squelched. I feel that each and every member of that June 1974 House of Delegates would have done organized medicine a great service by being willing to have his individual vote recorded, and I feel that the failure to do so was a disservice that might well contribute greatly to the additional fragmentation of organized medicine.

I hope that Indiana will be a leader in an effort to alter the mechanism so that a roll-call vote can be mandated in vital issues by a minority, so that the majority cannot again "cop-out" on such vital issues so easily. I make this appeal because I am fundamentally opposed to the fragmentation of the voice of medicine that some of our members as well as all of our opponents look forward to for various, if contradictory, reasons.

ELI GOODMAN, M.D.
Trustee

Fourth Trustee District

HOUSE ACTION: Ordered filed.



HOWARD JACKSON, M.D.
Trustee

The annual meeting of the Fourth District Medical Society was held at the Seymour Country Club, on Wednesday, June 12, 1974. Elections were held during the business meeting which began at 4:00 p.m.

Dr. A. A. Daftari, Batesville, was elected president. Dr. Robert Acher was elected vice president and Dr. Lanny Copeland of Osgood was elected secretary-treasurer. Dr. Howard Jackson was reelected trustee.

A lively discussion developed over PSRO, third party intervention, over the lack of communication among the physicians in the Fourth District and, in general, over the purpose and use of Fourth district dues money. It was determined by the delegates that fifty dollars ($50.00) per month would go to the trustee, in the interest of better communications among the physicians of the Fourth District. It was hoped that a form of newsletter could be developed and sent to each physician each month or at least after each Board of Trustee meeting.

The evening meeting was highlighted by the well received talk of Dr. Jose Oller. Dr. Oller is a New Orleans neurosurgeon and president of the Council of Medical Staffs. The substance of his talk was the basis for an article in the *Medical World News* of June 21, 1974. We learned a great deal from Dr. Oller's talk.

PSRO has become the most talked about issue in the medical community. It is predicted that PSRO will be the most divisive issue of our time. I believe this prediction is all too true. Much activity has been taken by several in the Fourth District, especially by Dr. Blaisdell, the alternate trustee, and by the Seymour Medical Society in an attempt to educate our patients and our legislators with the objective of repealing PSRO. Many feel that they will be unable to practice with these kind of punitive laws governing us. I hope that this activity will continue and will become more widespread in the Fourth District.

The Fourth District meeting in 1975 will be hosted by Ripley County at Batesville, Indiana. The date has not been determined as yet.

I want to thank all the physicians in the Fourth District for their cooperation, for their activity in the medical society and for their participation in the committees and commissions of ISMA.

HOWARD JACKSON, M.D.
Trustee

Fifth Trustee District

HOUSE ACTION: Ordered filed.



C. M. SCHAUWECKER, M.D.
Trustee

This has been a most productive year for the Fifth District. First, after six long years of trying to find some method of financing either an extensive remodeling program for the Putnam County Hospital, or building a new structure—and having absolutely no success—we were able to get a bill through the Indiana legislature that would allow proprietary hospitals to be built in Indiana and not be discriminated against by Blue Cross simply because they are proprietary in nature. We wish to make it perfectly clear that we are not suggesting that any other county follow this method, for we know that local financing and operation definitely have advantages. However, we do think it is important that those counties, like ours, who find themselves completely unable to finance the project by local taxes, now have another method to turn to. As this is being written, the ground has been purchased, and a survey team is at work. While much hard work on the part of the County Medical Society was primarily responsible, the fact that a new hospital is apparently going to be built in Greencastle certainly aided us greatly in recruiting two new family physicians who have begun practice here within the past month. One additional physician is planning on coming within the next one or two months, and another has agreed to come next July. It is our feeling that the combination of much hard work, by the local doctors, plus being able to offer the new prospective physician excellent facilities in which to practice, is the probable answer to getting new men to come to the outlying areas, and thus upgrade the practice of medicine in these areas.

A second most important event occurred, which was the instigating of an emergency ambulance system in conjunction with the Comprehensive Health Planning group in this area. This consists of Clay, Parke, Putnam, Sullivan, Vermillion and Vigo Counties (five of these counties make up the Fifth District). It is the goal of this group to have a well-equipped ambulance (one or more) in each of these counties and to have them manned by properly trained ambulance technicians 24 hours each day. The ambulance technicians, by means of two-way radio, will be in constant contact with the Emergency Room of St. Anthony's Hospital at Terre Haute, which is manned around the clock. They can also be in two-way contact with the local hospital, and thus receive constant supervision while at the scene, or during transportation of the patient to the respective hospital. EKG monitoring will be available for those cases where it is required. It is hoped that this will be in operation by this fall. To the best of our knowledge, this will be the first such program in the U. S.—where the coverage will be on the basis of the Comprehensive Health Planning Area. The people of the area owe a great debt of gratitude to Dr. Wilbert McIntosh for the tremendous amount of effort he put into this project.

Our annual Fifth District Meeting occurred at Turkey Run State Park on May 22, 1974. President Frank Swaim of Rockville called the business meeting to order at 4:00 p.m. It was well attended, and Dr. George Crane, the columnist, gave a most interesting and informative talk on present legislation before congress and how physicians could influence this legislation much more if they would only take the time and effort and get involved.

The election of new officers for the Fifth District was then held and the following were elected:

President: Paul Humphrey, M.D., Terre Haute

Secretary-Treasurer: Fred Dierdorf, M.D., Terre Haute

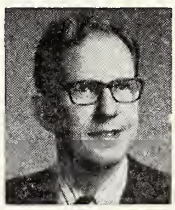
Following the business meeting, dinner was served to approximately 70 members. The main speaker was Dr. Crane, who gave an informative yet humorous talk. The talk centered chiefly on the common causes as to why husbands and wives stray. He used some personal cases to illustrate the talk and stressed the importance of psychology in marriage. The talk was very well received.

Next year's meeting will be at Terre Haute, but at this time the date has not been set.

CLEON M. SCHAUWECKER, M.D.
Trustee

Sixth Trustee District

HOUSE ACTION: Ordered filed.



PAUL M. INLOW, M.D.
Trustee

The need for primary care physicians is being felt in the Sixth District. There is now a public health physician in Rush County.

I feel there is a great need for the ISMA to implement our own state malpractice insurance company. The num-

ber of insurance companies writing malpractice insurance has continued to decrease.

The Sixth District Medical Society's annual meeting was held on May 9, 1974, at the Connersville Country Club with Dr. J. H. Tower, Jr., president, presiding. The members of the various commissions of the Indiana State Medical Association from the Sixth District were recognized and gave brief reports of activities of their respective commissions. A report was then given by the trustee and alternate trustee.

The Sixth District dues were raised to $5.00 a year.

The newly elected officers of the Sixth District are: President, Davis W. Ellis, Jr., M.D., Rushville; vice president, William Kerrigan, M.D., Connersville, and secretary-treasurer, Clarence Clarkson, M.D., Richmond.

Our evening speaker was David Crane, M.D., a Bloomington, Indiana, psychiatrist who discussed federal inroads into medicine and urged all physicians to continue their efforts to prevent such interference as much as possible.

PAUL M. INLOW, M.D.
Trustee

Seventh Trustee District

HOUSE ACTION: Ordered filed.



JOSEPH F. FERRARA, M.D.
Trustee

The Seventh District held its annual meeting on June 5, 1974, at the Speedway Motel, Indianapolis.

Golf was the order of the day and the prizes were won by Dr. John Records of Franklin and Dr. Ted Grissell of Indianapolis.

At the business meeting Dr. John Butler of Indianapolis was reelected trustee. Dr. Don McCallum of Indianapolis was reelected alternate trustee. Dr. John Records of Franklin was made president-elect and Dr. Malcolm Scamahorn of Pittsboro was reelected secretary-treasurer.

President of the Seventh District Medical Society for this year will be Dr. Ray D. Miller of Martinsville and of the Morgan County Medical Society. They will be the host for the 1975 meeting.

PSRO was the topic of discussion and it was quite apparent that most of those attending were for repeal of the law and not implementation. They were told that the ISMA Board of Trustees stood opposed and were for repeal. Dr. Scamahorn reported that our delegates to the AMA voted against PSRO and for repeal of the law and further stated this was the attitude of the AMA House of Delegates.

Our dinner speaker was David Crane of Bloomington, and *guess* what his subject was: PSRO. Dr. Crane suggested that we stimulate the public—the voters—to write to their congressmen, especially since this is an election year. He also suggested writing letters to the editors of newspapers and, when printed, sending the whole page to the congressmen. He mentioned that the law makes the HEW secretary a czar over medicine, and decisions on issues concerning doctors and the practice of medicine will be at the discretion of the HEW secretary.

Also, confidentiality of medical histories and reports was stressed. Confidentiality is already being destroyed and will get worse. There was mention of a case of a woman in California and in her medical history there was mention that at one time she was a prostitute. This went thru the computer and became public—as a result—a lawsuit.

We were told medical forms at present are being standardized for computerization and it was mentioned that Federal Bureaus have called up I.R.S. tax returns which are supposed to be confidential.

So what can happen to medical reports?

There was a very hot and lively discussion from the audience concerning PSRO and the tenor was for repeal of the law—not implementation.

Also, there was a definite feeling that the AMA was not representing the doctors' stand for repeal.

At any rate, I believe everyone present was convinced that Johnson County was for repeal of the law and not implementation.

This has been a trying year on the Board what with the government's interference in medicine in many various ways and all that we, as doctors, have to do is be divided and we will be conquered.

One thing for sure—a representative or trustee sure can't please everybody he represents.

JOSEPH F. FERRARA, M.D.
Trustee

Eighth Trustee District

HOUSE ACTION: Ordered filed.



RICHARD INGRAM, M.D.
Trustee

The annual meeting of the Eighth Medical District was held at the Anderson Country Club on May 29, 1974. There was golf in the afternoon for those interested. In the evening there was a business meeting.

Interesting highlights of the business meeting included a resolution passed that members of the Eighth District would not participate in further governmental medical programs. Another interesting point of the meeting was that the Eighth District Association recognizing the paucity of information that it has had concerning various bits of legislation coming up in our national congress, has asked that at their own cost, excerpts and abstracts of pending health legislation bills be circulated to all members of the Eighth District. This reflects concern by all members in the Eighth Medical District concerning the recent inroads on medicine by the government.

Elections were also held at this meeting. The president-elect of the Eighth District Medical Society is Dr. Eugene Gillum of Portland. The secretary-treasurer is Dr. James Fitzpatrick of Portland.

The meeting was then adjourned and an enjoyable evening was had. There was a large banquet with Dr. Otis Bowen, Governor of the state of Indiana as the main speaker of the evening.

RICHARD INGRAM, M.D.
Trustee

Ninth Trustee District

HOUSE ACTION: Ordered filed.



WILLIAM SHOLTY, M.D.
Trustee

The 1974 Ninth District Medical meeting was held Thursday, June 13, 1974, at

the Frankfort Country Club. The Clinton County Medical Society was host. Dr. Lee Dupler served as general chairman.

The business meeting was well attended (32). Dr. Vincent Santare, chairman of the ISMA Board of Trustees, discussed PSRO problems. Dr. James Harshman, AMA delegate and Eleventh District trustee, discussed the problems between the AMA Board and the House of Delegates. Dr. Peter Petrich, our Blue Shield representative, discussed Blue Shield problems, peer review and the Future Planning Committee. Dr. William Sholty announced that he had a copy of the slides prepared by Dr. Blaisdell. These are offered for anyone's use in the district. These bring out the bad points of PSRO.

Mr. Steve Tope, representative of the Blue Cross-Blue Shield, was introduced.

We had an innovation as far as the Ninth District was concerned. Each Ninth District commission representative gave a report on his commission. This was very well received. Dr. Max Hoffman was reelected our alternate trustee.

Next year's host will be the Jasper-Newton County Medical Society. The location and the date of the meeting has not been announced.

Mr. Phil Wise gave the program at the dinner meeting. He is a local humorist and the program was well received.

WILLIAM SHOLTY, M.D.
Trustee

Tenth Trustee District

HOUSE ACTION: Ordered filed.



VINCENT J. SANTARE, M.D., Trustee

The Tenth District, as represented by Lake County, began its year with the inauguration of Dr. Walfred (Chick) Nelson as president of Lake County Medical Society in January at the Merrillville Holiday Inn. At this meeting Governor Otis R. Bowen was the speaker and Senator Vance Hartke also attended the meeting and spoke to the society on pertinent local political problems. Dr. David Ross of Gary was installed as vice-president and Dr. Thomas Gehring of Merrillville as secretary of the Lake County Medical Society.

During the course of the year, the Calumet Foundation for Medical Care applied for a planning grant for PSRO activities and was approved for such a grant. The Foundation has been endorsed and consists of members of Lake and Porter county medical societies. Since the PSRO area also includes LaPorte County, a new organization will be set up named CALPRO, which will plan for peer review activities in the three county area. Directors of CALPRO organization will be selected from the Bed Utilization Review Committees of each of the hospitals in the three county medical societies, and an attempt will be made to restrict this particular function to the physicians of the area.

Dr. Alfred Kobak of Valparaiso has presided as the president of Porter County Medical Society. He will be succeeded by Dr. Leon Armalavage of Valparaiso. The Porter County Medical Society had an interesting county meeting on PSRO activities, and has been active in the establishment of Emergency Medical Services in this county.

The Tenth District meeting was postponed until September 25, 1974. The meeting will be held at the Valparaiso Country Club. The election of a Trustee to succeed Dr. Vincent J. Santare will be held at this meeting.

VINCENT J. SANTARE, M.D.,
Trustee

Eleventh Trustee District

HOUSE ACTION: Ordered filed.



JAMES A. HARSHMAN, M.D. Trustee

Last year my report dealt with three areas of concern which were being discussed in the Eleventh District, namely, the physician shortage, PSROs and drug abuse. The same report could have been submitted again this year and a few more items could be added to the list, such as delineation of staff privilege, increasing governmental interference with the private practice of medicine, confidentiality of medical records and national health insurance, to name a few. The solutions to these and other problems will not be easy, and in many instances, not to our liking. Organized medicine still remains our most effective means by which we can address the problems. For this reason, it is imperative that all physicians participate in activities of their respective societies.

Our annual meeting was held last year at Marion where we observed the 125th Anniversary of the Grant County Medical Society. There was a large turnout for the event.

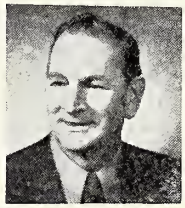
Election for district officers was held and Dr. Joe Bean was elected president, Dr. Fred Poehler was elected secretary-treasurer.

Cass County will host our next meeting which will be held on September 18, 1974, at Logansport.

JAMES A. HARSHMAN, M.D.
Trustee

Thirteenth Trustee District

HOUSE ACTION: Ordered filed.



G. BEACH GATTMAN, M.D. Trustee

The Thirteenth District Medical Society held its annual meeting at Plymouth, September 12th. Preceding the meeting a golf outing was held at the Plymouth Country Club.

The business meeting was held at the American Legion Club of Plymouth and we had the best attendance of our district in a number of years. Dr. James Rimel, president of the district, conducted the meeting. Along with the usual business we also had reports from the commission members highlighting their activities for the year. The trustee's report was next, highlighting the Board of Trustees activities for the year. Dr. James H. Gosman, president of ISMA, gave a short talk.

Dr. Jack Hannah, Elkhart, was elected president for 1973-74; Dr. John Hildebrand, Jr., South Bend, was elected president-elect; Dr. David Spaulding, Mishawaka, was reelected secretary-treasurer. Dr. Donald Chamberlain, South Bend, was reelected alternate trustee.

Following the regular business meeting there was a panel discussion on PSRO with Dr. James Harshman, trustee of the Eleventh District and an AMA delegate, who gave a very thoughtful dissertation.

Following dinner a drawing was made for door prizes.

Our main speaker for the evening was Dr. Otis R. Bowen, Governor.

Our district had several extra meetings during the past year. The first was for delegates and officers of the county societies, which was poorly attended. The second was with the St. Joseph County Society and both of these had to do with PSRO.

The next meeting of the district will be at the Elcona Country Club in Elkhart on September 12, 1974.

G. BEACH GATTMAN, M.D.
Trustee

Editor of The Journal

HOUSE ACTION: Order filed.

The budget for *The Journal* for this fiscal year was established with the expectation of a deficit. However, the financial picture was accurately predicted and, while various items in the budget have varied, the totals are within the total budget and should also be in balance on September 30.

The Roster Issue is the most expensive one of the 12 but it is also probably the most useful. The Roster this year was the largest ever. It contains reference information which has been increased a little each year. Its printing bill was a little over $10,000, about five times the cost of the average issue.

National advertising revenue for the first half of the fiscal year is off by a few hundred dollars but state and local advertising was up by over $1000, making the total ad revenue for that period some $360 over the same period last year.

Special issues, other than The Roster, were one commemorating the recent additions to St. Francis Hospital of Beech Grove, the usual February Heart Month issue for cardiovascular disease, and the March issue which highlighted geriatrics.

A new addition is a series of Seminars from Riley Children's Hospital under the general sponsorship of Dr. Joseph F. Fitzgerald, associate professor of pediatrics. This series will continue indefinitely on an approximately bi-monthly basis.

This year *The Journal* has been well supplied with scientific articles. In fact, the limitation of size of issues due to the low advertising revenue has changed what would be a normal supply into an overabundance.

FRANK B. RAMSEY, M.D.
Editor

Delegates to AMA

HOUSE ACTION: Ordered filed.

Indiana's delegates to the American Medical Association's 123rd annual meeting, June 22 through 27, in Chicago, returned home defeated on two of their major undertakings.

The campaign to reelect Dr. Donald E. Wood, Indianapolis, to a second term on the Board of Trustees and the delegation's effort to stimulate a tide for repeal of PSRO both met with disaster.

A general uprising seemed to be the mood of the House of Delegates when only one former trustee was returned to his office. All the other vacancies, five in fact, were filled by new members of the board.

PSRO stance of the House of Delegates was a shocking one as far as the Indiana delegates were concerned. The ISMA had introduced a resolution before the House calling for direct repeal of the provisions of PSRO and Public Law 92-603. Reference Committee "A" had 25 resolutions dealing with PSRO before it for consideration.

Scheduled as a special order of business for 1:00 Wednesday afternoon, the House suspended the rules to take up Item 21 of Reference Committee A's Report, which dealt with the PSRO situation. The Chair called upon the chairman of the Reference Committee to review section 21 of their report, which he did, and then the political maneuvers began. A Dr. Hildebrand of Wisconsin was immediately recognized after the report was read. Dr. Hildebrand called for adoption of the Reference Committee Report and called for the previous question, which was to terminate debate. The question of closing debate carried by a standing vote of 202 to 24.

The adoption of the Reference Committee Report was then placed before the House and it carried by a vote of 185 to 57. This ended all debate on the PSRO question and the statement adopted by the House of Delegates is as follows:

> RESOLVED, That this House of Delegates instruct the Board of Trustees of the Association to direct its efforts to achieve constructive amendments to the PSRO law and to ensure appropriate regulations and directives, with particular effort directed at amending those sections of the law which present potential dangers in the areas of confidentiality, malpractice, development of norms, quality of care, and the authority of the Secretary of HEW; and be it further
>
> RESOLVED, That the Association should continue its efforts to achieve legislation which allows a profession to perform peer review in accordance with the profession's philosophy and the best interest of the patients; and be it further
>
> RESOLVED, That individual state associations which elect non-participation shall not be precluded from such a position by this association's policy statement, but should be urged to develop effective non-PSRO review programs which embody the principles endorsed by the profession as constructive alternatives to PSRO; and be it further
>
> RESOLVED, That if ongoing evaluation of the PSRO program reveals that it does, in fact, adversely affect the quality of patient care, or conflict with association policy, the Board of Trustees be instructed to use all legal and legislative means to rectify these shortcomings.

The Indiana Delegation made a strong stand for repeal of PSRO in the Reference Committee and on the floor of the House prior to the reading of the Reference Committee report.

Eugene F. Senseny, M.D., Fort Wayne, was floor leader of the delegation who attended the meeting in full force. Working throughout the long meeting with early morning breakfast meetings and continuing caucuses were Delegates James A. Harshman, M.D., Kokomo; Malcolm O. Scamahorn, M.D., Pittsboro; Patrick J. V. Corcoran, M.D., Evansville; and Lowell H. Steen, M.D., Hammond.

Alternates attending were A. Alan Fischer, M.D., Indianapolis; Ross L. Egger, M.D., Daleville; Kenneth O. Neumann, M.D., Lafayette; Thomas C. Tyrrell, M.D., Hammond; and Peter R. Petrich, M.D., Attica.

Also in attendance were President Joe Dukes, M.D., Dugger; President-elect Gilbert M. Wilhelmus, M.D., Evansville; and Board Chairman Vincent J. Santare, M.D., Munster.

Also working with the delegation were Frederic Schoen, M.D., Fort Wayne, alternate delegate from the AMA Section on Family and General Practice; Joseph E. Walther, M.D., Indianapolis, delegate, AMA Section on Gastroenterology; Sprague H. Gardiner, M.D., Indianapolis, delegate AMA Section on Obstetrics and Gynecology; Myron H. Nourse, M.D., Indianapolis, delegate, AMA Section on Urology; and Guy A. Owsley, M.D., Hartford City, member of the AMA Council on Medical Service.

Among other guests who attended a breakfast meeting with the delegation were David G. Crane, M.D., Bloomington, chairman of the ISMA's Commission on Public Information, and his father, George Crane, M.D., noted health columnist.

In addition to the controversial PSRO issue, the AMA House of Delegates established a change in the method of electing AMA trustees, approved the need for additional safeguards to preserve the confidentiality of medical records, and new recommendations which affect the relationship between hospitals and hospital medical staffs.

Meeting for a total of 19 hours and 38 minutes, the House acted on 66 reports and 137 resolutions for a total of 203 items of business.

The House approved bylaws changes which replace the "slot method" of electing trustees by the "simultaneous election of candidates to several positions of equal rank," in which all candidates run for board vacancies on a single ballot. Under the new method, trustees for full, three-year terms are elected first, followed by the selection of trustees to fill unexpired terms. Election of the AMA president-elect, vice-president, and speaker and vice-speaker of the House remains on a separate basis.

Delegates selected Max Parrott of Portland, Oregon, as president-elect. In addition to Dr. Parrott, others elected or reelected to positions in the Association were: vice-president—Joseph M. Ribar, Alaska; speaker of the House—Tom E.

Nesbitt, Tennessee (reelected); vice-speaker of the House—William Y. Rial, Pennsylvania (reelected); trustees, for three-year terms—Daniel Cloud, Arizona; James M. Blake, New York; Hoyt D. Gardner, Kentucky; Raymond T. Holden, District of Columbia (reelected). For the unexpired two-year term of James H. Sammons, AMA executive vice-president-designate, Frank J. Jirka, Illinois, and for the unexpired one-year term of Dr. Parrott, Joe T. Nelson, Texas.

Addressing the House on Tuesday, June 25, Vice President Gerald Ford advocated some form of national health insurance but warned that in the process of its development there should be no further erosion of patient confidentiality. Though it had been rumored that Ford would address the PSRO issue, his only passing reference was:

"I've been getting a lot of free advice lately on how to run my business. I have not necessarily followed this advice. So, I won't give you any free advice on how to run your business. In my view on PSRO, (P)oliticians (S)hould (R)emain (O)ut of it."

Ford said a national health insurance program is necessary because of the prohibitive cost of catastrophic illnesses and the need to more effectively use and distribute medical resources. While declaring the physician should work for his patients and "not for the bureaucrats in Washington," he added that the "government must do for the individual citizen what he cannot do for himself."

In his inaugural address on Wednesday, June 26, Dr. Malcolm C. Todd, the new AMA president, urged the AMA to sponsor the development of a "national policy on health" to place needs and goals in focus. He said "a tremendous amount of confusion" exists on the health-care scene and is reflected in plans being advanced in Washington and elsewhere.

"It is high time to put the health-care state of the Union into its true perspective, before lack of perspective leads to waste of effort, waste of money, waste of hope," he said.

Dr. Todd asked the delegates to consider sponsoring a National Academy of Health to formulate his proposed national policy. The academy, he said, would give both private and public sectors of health care "an open forum and framework in which to exchange views, pinpoint health-care needs, evaluate total health care resources, and arrive at some common sense of purpose, with sound programs, goals and priorities."

Dr. Todd noted a national policy on health also is called for in Congressional bills that would make health services a public utility. Under one such proposal, a five-man federal commission would make policy recommendations. Such a policy would be "destructive," he said, unless the private sector of care seizes the initiative in formulating it.

Two statements on national health insurance were adopted after lengthy debate. One calls on the Board of Trustees to cooperate with state associations "to attempt to devise mechanisms mutually acceptable to the private medical and insurance communities which will ensure the provision of health insurance coverage through the purchase of private health insurance, and to seek means to secure favorable Congressional and public support for their adoption."

During discussion, it was pointed out that the addition to the NHI policy does not affect AMA support for Medicredit, but is intended to stimulate new health insurance mechanisms. The second resolution calls on the AMA and component associations to work to detach "any national health insurance program from the controlling intrusions of existing PSRO laws and regulations."

The House adopted two resolutions bearing on drugs. One directs the AMA to continue its support of the pharmaceutical industry in efforts to develop and market pharmaceutical products meeting proper standards of safety and efficacy. The other resolution directs the AMA to "exert all efforts to amend or repeal the Kefauver-Harris" drug amendments of 1962, which gave the FDA broad new powers in drug manufacturing and marketing, and which critics of the FDA contend has tended to stifle the developing and marketing of new drugs in the United States.

The House went on record as being opposed to certain bills in Congress which would replace the federal "Health Professions Educational Assistance Act" which expired June 30. Under the bills, comprehensive health planning programs would be replaced with public utility-type bodies which would control certain aspects of health education and health-care delivery, and medical licensure. An amended resolution adopted by the House directs the Board of Trustees to mobilize AMA membership in opposition to offensive sections of the proposed legislation and take strong actions on other fronts.

In other actions affecting physicians and the government, and other third parties, the House:

—Directed the AMA to seek an extension of from 30 to 90 days to respond to proposed health regulations printed in the Federal Register, and to see that government agencies using the Federal Register for rule-promulgating purposes be urged to hold public hearings on the merits of proposed legislation.

—Called on the AMA to oppose the concept of claims rejection on the basis of "diagnostic admission" or "lack of medical necessity" without prior physician notification, and to recommend a peer review mechanism be established independent of the third-party carrier to review claim conflicts with such mechanisms to be established by existing medical foundations, medical societies or other independent peer review organizations.

—Requested the AMA to work with third parties to secure increased acceptance of the AMA uniform health insurance claim form and urged state associations to encourage acceptance of the form by insurance commissioners, and, if necessary, through state legislation.

—Urged continued AMA efforts to prevent future imposition of government fee controls, and opposed the mandatory imposition of a "Healthcard" as the payment mechanism under the administration's national health insurance plan, and instead, reaffirmed the right of the physician to bill patients directly.

—Adopted two reports bearing on confidentiality of medical records. Report I of the Council on Medical Service described a wide-ranging series of proposals to enable the medical profession and insurance companies to "maintain the confidentiality and security of patient information." Report S of the Board of Trustees noted that the Council on Legislation is developing model legislation as a guide to possible state legislation to preserve confidentiality and that a model bill should be ready for consideration by the House at the 1974 Clinical Session in Portland, Oregon.

In another action affecting physicians and the public, the House directed that the AMA continue to inform the public and the profession of the potential problems and risks in permitting the nonphysician substitution of drugs of choice prescribed by physicians and that state associations support this position before state legislatures considering laws which would allow drug substitutions.

The House adopted the 104-page "Report on Physician-Hospital Relations, 1974," compiled by the Council on Medical Service and its Committee on Private Practice. An update of an earlier report made in 1964, the 1974 version contains 14 specific recommendations to cope with problems developing between some hospitals and their medical staffs. Among other things, the recommendations are aimed at protecting medical staffs against unilateral action by hospital governing boards relative to staff by-laws, rules and regulations.

A resolution calling on the AMA and constituent societies to "institute a nationwide public education program to inform the public" of malpractice problems, and for the AMA to "spearhead state and federal legislation" to correct malpractice inequities, was referred to the Board of Trustees and its Committee on Insurance for report back at the 1974 Clinical Session.

JAMES A. HARSHMAN, M.D.
EUGENE F. SENSENY, M.D.
MALCOLM O. SCAMAHORN, M.D.
PATRICK J. V. CORCORAN, M.D.

LOWELL H. STEEN, M.D.
Delegates
A. ALAN FISCHER, M.D.
ROSS L. EGGER, M.D.
KENNETH O. NEUMANN, M.D.
THOMAS C. TYRRELL, M.D.
PETER R. PETRICH, M.D.
Alternate Delegates

Supplemental Report of Delegates to AMA

HOUSE ACTION: Ordered filed.

I have asked for permission to make a very short speech, basically to express my thanks to this House, and to present what I consider to be some rather hard facts. This is not a very happy time for me basically for two reasons—I am somewhat remorseful about my personal decision because I have really enjoyed my job for all of you. And, number two, I don't like to bring you the facts, but I can't honestly leave without doing it. I am resigning after eight active years in the American Medical Association House as one of your representatives from the Indiana State Medical Association, but more specially as a child of this very House. I do so without any animosity. My reasons are purely personal. At the age of 52, I find myself very swamped with personal work, and I am involved in a three million dollar medical clinic project, plus the fact that my wife and I currently have two children in college and next year it will be three. These are very personal things, but I feel I owed all of you who had supported me an explanation. Despite what a wonderful husband and father I have been, I do owe Dee and the children a little better shake than they've probably had for many years. The job has been fun, but it's not all sweetness and light. Anyone who aspires to this high office must realize this. In addition, it takes personal sacrifice and time and money. One is not always held in high esteem with this job, as you have all witnessed these past several years. I knew this going in. If a man can't take the heat, or he won't give a hundred percent to the office, he shouldn't be elected! The good news—you can't imagine the many extremely fine people I have met over the years. Friendships not to be forgotten. Most of these have been honorable, intelligent men trying to work in concert in the best interest of the general public's best health interest, and also honest vested interest concerning your feeedom to practice free in a free society. I shall never forget these people.

I have asked for the privilege of the floor to also make some constructive remarks. The delegation, both delegates and alternates and section delegates, I think they've done an exceptionally good job over the years, but I would assume that we cold have done better. And I include myself in that criticism. I think this House, at a more appropriate time than today owes Dr. Donald Wood a true accolade for his 40 years of dedication to all of us on both the local, state and national levels. What happened in Chicago—I want to try to tell you. Number one. The *World Medical News* article certainly was very self-defeating to a certain degree to Doctor Wood's candidacy. Number two, we may not have worked as diligently as we could have, and again, I included myself in this introspection, but I fault no delegate or delegates. I would like to stem any ugly rumors that have arisen. I think the delegation, the alternates, supported Don. There is no question in my mind, I couldn't testify to the contrary. Number three, we went to the annual session committed by this House to vote for the repeal of PSRO, and this we did. This, in essence, took Doctor Wood down the tube. I feel that I can substantiate my remarks. Gentlemen, you don't have to be a political genius to realize that the Congress is not going to repeal a law and admit that they were wrong, especially when it even hasn't been tested. I say this despite what you have heard and will be hearing from certain quarters. The only repeal that I can think of in this country involved booze or prohibition. I have always felt that that was the finest thing that President Roosevelt did in four terms. We went down to Chicago like a bunch of Kamikaze Pilots, and, in my opinion, made a horrendous and terrible mistake. We are now devoid of the mother's milk in this business, namely, we have lost our trustee on the AMA Board. I am disturbed when I see some of the same self-destruct resolutions coming up again. I take as a personal affront resolutions which in a veiled manner imply that the House didn't act properly. The overwhelming voice of the House was to accept reality, as bitter as it is for every one of us. The Indiana delegation to a man sustained your mandate to us. Doctor Wood lost his job. If we persist we will have nothing as bad as you might feel the AMA to be. It is all you have left, and to talk of withdrawal and removal of financial support, in my personal opinion is foolhardy. We must reassess our posture from a very pragmatic standpoint. For example, when you review candidates for this high office, you must, of course, look beyond single-issue oriented men. PSRO is but one problem. Look at the monumental issues before your Reference Committees. I am speaking of competency, relicensure, malpractice—just to mention a few.

I have tried to offer these remarks in a most constructive and critical manner. They are my personal opinions, but they are based on years of service, and because of my deep and genuine concern for the Indiana State Medical Association now and in the future. If I didn't give a damn, I could have folded my tent and said nothing. Finally, I have tried to serve you well, objectively, and I have tried today to afford you the benefit of this experience which you offered me. Lastly, I want to express my eternal gratitude to the House.

EUGENE F. SENSENY, M.D.
Delegate

Reports of Committees

EXECUTIVE COMMITTEE

HOUSE ACTION: Ordered filed.

The Executive Committee met at the conclusion of the Board of Trustees meeting following the Annual Convention, and welcomed Drs. Vincent Santare and William Clark as new members. By secret ballot, Dr. Donald M. Kerr was elected chairman of the Executive Committee for the coming year.

The officers then signed the various bank cards and necessary papers. There being no other business, the meeting adjourned.

The Executive Committee met on five occasions since the last Convention, having met on November 10, 1973, January 19, March 12, April 20 and June 15, 1974.

Inasmuch as the minutes of the meetings of the Executive Committee have been published in THE JOURNAL, and copies are available for each member of the reference committee, I will save your time by not going into detail in reviewing each of these meetings.

The Committee in its meetings has been involved heavily in a large number of items which came before it, many of which were referred to the Board of Trustees for their review, and action in each matter adopted by the Executive Committee was sent to the Board of Trustees for their concurrence.

On March 13, 1974, the Executive Committee made its annual trek to Washington and hosted a dinner for the Indiana delegation in Congress. We spent a day visiting the congressmen and their offices, and concluding our day's activities with a reception and dinner. It was interesting that this year, for the first time, both senators and all 13 of the congressmen showed up for the dinner activity. It is the belief of all of us who met with them that we made quite a few brownie points with our Indiana delegation, and we are sure that we developed a much closer liaison with them, which will be necessary in coming

months as legislation is presented before Congress. At least we believe we have a method now of communicating with them and expressing our views on much of this legislation.

The Committee met on January 19 for the purpose of regular activities, plus preparation of the budget for the fiscal year ending September 30, 1974. After review of the budget and discussion, the matter of the budget was referred to the Board of Trustees for their approval.

Medical Defense Activities

1. Malpractice Cases. A year ago at the time of this report, August 1973, the following six cases were pending before the committee:
   Case 307 — Suit filed March 22, 1962. Closed. (Expense $1,497.73)
   Case 313 — Suit filed September 5, 1967. Pending. (Expense to date $600.00)
   Case 314 — Suit filed approximately July 6, 1970. Pending.
   Case 316 — Suit filed July 2, 1970. Pending.
   Case 317 — Date suit was filed unknown. Closed. (Expense $644.00)
   Case 318 — Date suit was filed unknown. Pending.
   Since August 1, 1973, and to August 1, 1974, three new cases have been filed.

2. Medical Defense Fund Statement from July 1, 1973, to June 30, 1974;

Bank balance, July 1, 1973	$19,891.06
Receipts	6,328.85
Total cash and receipts, June 30, 1974	26,219.91
Disbursements	1,462.95
Balance on hand, June 30, 1974	$24,756.96
U. S. Treasury Bonds	25,526.53
Due from General Fund	720.15

The Journal

Listed below is a comparative report of *The Journal* operations over the past several years and the first six months of 1974, as follows:

The first table shows the number of journal pages for the past six years (includes inserts).

Year	Reading	% Reading	Adv. Pages	% Adv. Pages	Total Pages	Av. No. Pages Per Issue
1968	1068	61	696	39	1764	147
1969	1041	67	509	33	1550	129
1970	1131	74	403	26	1534	128
1971	970	70	426	30	1396	116
1972	933	69	433	31	1366	113
1973	877	73	321	27	1198	100

The table below shows the total printing costs of *The Journal:*

Year	Total Printing Costs	No. of Pages
1969	$42,916.62	1312
1970	44,520.84	1346
1971	40,542.21	1232
1972	41,789.70	1106
1973	42,642.43	1028
1974 (6 mos.)	24,786.99	560

A comparison of advertising revenues for the first six months of the last four years, with a like figure for 1974, is as follows:

Year (Jan.-June)	Sold by State Medical Journal Adv. Bureau	Sold direct By Journal	Total
1970	$15,791.12	$2,268.80	$18,059.92
1971	13,128.30	1,821.89	14,950.19
1972	17,869.96	1,622.60	19,492.56
1973	10,938.94	2,134.95	13,073.89
1974	10,280.92	3,151.00	13,431.92

Membership Report

Total Members

	December 1972	December 1973
ISMA	4,587	4,698
AMA	4,246	4,348
	July 31, 1973	July 31, 1974
ISMA	4,625	4,743
AMA	4,292	4,416

DISTRICT REPORT AS OF JULY 31, 1974
+ Gain — Loss

District	ISMA	AMA
1	+ 12	+ 13
2	+ 9	+ 2
3	+ 6	— 2
4	+ 1	+ 4
5	— 5	— 4
6	+ 2	+ 6
7	+ 43	+ 45
8	— 3	+ 11
9	+ 2	+ 2
10	+ 34	+ 27
11		+ 4
12	+ 16	+ 15
13	+ 1	+ 1
	+118	+124

DEATHS

December 1973	59
As of July 31, 1974	28

COUNTY/DISTRICT MEMBERSHIP REPORT

	Dec. 31, 1973 ISMA	July 31, 1973 ISMA	July 31, 1974 ISMA	July 31, 1974 AMA
1st DISTRICT				
Gibson	11	11	13	13
Perry	7	7	7	7
Pike	2	2	2	2
Posey	6	6	6	6
Spencer	5	5	4	4
Vanderburgh	274	268	279	261
Warrick	6	6	6	5
TOTAL	311	305	317	298
2nd DISTRICT				
Daviess-Martin	19	18	20	15
Greene	16	16	16	12
Knox	45	45	44	42
Owen-Monroe	97	96	102	83
Sullivan	14	13	15	14
TOTAL	191	188	197	166
3rd DISTRICT				
Clark	54	53	55	43
Dubois	23	23	24	21
Floyd	47	46	44	41
Harrison-Crawford	9	9	9	9
Lawrence	40	37	41	35
Orange	6	6	6	6
Scott	8	8	8	8
Washington	8	7	8	7
TOTAL	195	189	195	170
4th DISTRICT				
Bartholomew-Brown	64	64	69	57
Dearborn-Ohio	14	15	15	14
Decatur	10	10	8	8
Jackson-Jennings	21	21	20	20
Jefferson-Switzerland	28	28	27	24
Ripley	11	11	11	10
TOTAL	148	149	150	133
5th DISTRICT				
Clay	15	15	14	14
Parke-Vermillion	14	14	14	13
Putnam	20	20	18	18
Vigo	125	121	119	115
TOTAL	174	170	165	160
6th DISTRICT				
Fayette-Franklin	18	18	18	17
Hancock	26	25	26	25
Henry	39	38	38	34
Rush	12	12	12	12
Shelby	22	20	22	20
Wayne-Union	76	75	74	70
TOTAL	193	188	190	178

7th DISTRICT				
Hendricks	23	23	26	21
Johnson	36	36	35	32
Marion	1121	1090	1129	1125
Morgan	22	21	23	21
TOTAL	1202	1170	1213	1199
8th DISTRICT				
Delaware-Blackford	127	127	131	103
Jay	17	17	14	13
Madison	106	103	97	75
Randolph	16	16	18	13
TOTAL	266	263	260	204
9th DISTRICT				
Benton	9	9	7	6
Boone	16	16	18	15
Clinton	15	15	13	11
Fountain-Warren	12	12	11	10
Hamilton	17	17	18	13
Jasper	9	9	9	9
Montgomery	24	24	25	25
Newton	5	5	4	4
Tippecanoe	158	154	157	144
Tipton	10	10	12	12
White	9	9	8	8
TOTAL	284	280	282	257
10th DISTRICT				
Lake	448	440	475	435
Porter	78	78	77	75
TOTAL	526	518	552	510
11th DISTRICT				
Carroll	8	8	8	8
Cass	32	32	31	27
Grant	79	79	82	81
Howard	72	72	71	67
Huntington	18	16	18	17
Miami	13	13	13	13
Wabash	30	30	27	21
TOTAL	250	250	250	234
12th DISTRICT				
Adams	12	12	13	13
Allen	318	317	327	299
DeKalb	19	19	19	15
LaGrange	11	11	9	9
Noble	14	14	16	16
Steuben	12	13	13	13
Wells	44	44	51	50
Whitley	15	15	13	13
TOTAL	445	445	461	428
13th DISTRICT				
Elkhart	115	114	118	107
Fulton	8	8	7	7
Kosciusko	13	13	18	14
LaPorte	101	101	94	82
Marshall	19	19	19	18
Pulaski	4	4	4	2
St. Joseph	245	243	243	242
Starke	8	8	8	7
TOTAL	513	510	511	479

SUMMARY

1st District	301	305	317	298
2nd District	191	188	197	166
3rd District	195	189	195	170
4th District	148	149	150	133
5th District	174	170	165	160
6th District	193	188	190	178
7th District	1202	1170	1213	1199
8th District	266	263	260	204
9th District	284	280	282	257
10th District	526	518	552	510
11th District	250	250	250	234
12th District	445	445	461	428
13th District	513	510	511	479
	4,698	4,625	4,743	4,416

DONALD M. KERR, M.D., *Chairman*
JOSEPH E. DUKES, M.D.
GILBERT M. WILHELMUS, M.D.
VINCENT J. SANTARE, M.D.
HUGH K. THATCHER, JR., M.D.
WILLIAM R. CLARK, M.D.

Grievance Committee

HOUSE ACTION: Ordered filed.

The Grievance Committee has not met during the past year as most of the complaints received have been handled by the local county medical society. Three new complaints were received, one has been resolved, the other two are pending. Of the six cases pending as of August 1973, one has resulted in a law suit, one has been resolved, and the other four are pending with no further word being received. In view of the nature of the complaints and the information received, calling a meeting of the committee was not deemed necessary.

The county medical societies are to be commended for handling more and more complaints at the local level.

The Grievance Committee wishes to thank the members of ISMA who have been called upon to assist in discharging its responsibility.

RICHARD S. BLOOMER, M.D., *Chairman*
WILLIAM D. PROVINCE, M.D.
EUGENE S. RIFNER, M.D.
KENNETH WILHELMUS, M.D.
HARRY L. CRAIG, M.D.
THOMAS C. TYRRELL, M.D.
LAWRENCE K. MUSSELMAN, M.D.
GENE MOORE, M.D.

Future Planning

HOUSE ACTION: Adopted with the portion concerning optional one-day meeting referred to the Board of Trustees and the portion on restructuring of committees and commissions referred to the Commission on Constitution and Bylaws, to voted on by the 1975 House of Delegates.

The Future Planning Committee has held two meetings, April 20 and June 15, both at the Association headquarters.

Resolution 73-11, referred to the committee by the House of Delegates, urged that the House of Delegates have a meeting in April or in May; and if a second meeting be needed, that it be held in October—November, and that only one of these be accompanied by a scientific session. After extensive discussion, the committee recommends that Resolution 73-11 not be implemented. It was further decided, on the basis of past experience with special meetings of the House of Delegates, that the present format of one annual meeting in October be continued, but that a poll of the next meeting of the House of Delegates be made to determine the advisability of holding an optional one-day spring meeting to deal with urgent matters including impending legislative issues.

In view of the steadily decreasing participation and support of exhibitors in the annual convention, with consequent loss of revenue, the committee urges that specialty societies be contacted with a proposal that their meetings be jointly scheduled with those of the ISMA. The favorable experience of joint sessions of the Section on Internal Medicine with the regional meetings of the College of Physicians and the Indiana Society of Internal Medicine serves as a favorable harbinger of the potential benefits, somewhat comparable with the annual meeting of the Kentucky Medical Association with its component specialty societies. In particular, the Indiana Academy of Family Physicians has led the way in demonstrating what can be accomplished in this area. The committee strongly endorsed initiating negotiations with the Indiana Academy of Family Physicians in jointly developing this concept.

A communication from Dr. C. Dyke Egnatz of Schererville about the convention format was considered. It embodied suggestions essentially consonant with the foregoing recommendations. It was directed that a letter of thanks to Dr. Egnatz express appreciation of his contribution.

The committee recommended that the subject of fees for professional services, for surgical assistants, for salaries to interns and residents, for charges for laboratory screening procedures not ordered by physicians, for emergency department services and various other third-party economic intervention into medical practice be referred to the Commission on Medical Economics and Insurance for further study and recommendation.

The committee commission structure of the Association was also considered. It was concluded that standing committees, such as the Executive Committee, Future Planning, and Sports and Medicine Committee, should not be disturbed nor should the standing and the ad hoc committees of the Board of Trustees be altered. Likewise, appropriate ad hoc committees for special needs should continue to be appointed by the president and

disbanded when they have accomplished their task.

It is suggested that a new commission structure be established with appropriate committees to carry out missions assigned to them. Each committee should be carefully evaluated as to its mission and there should be careful definition of goals and objectives for each commission. Each commission would be composed of seven members and whether these should be selected geographically could be a matter for determination at a later date. Committees of the commissions should be not more than five members and may be drawn from members of the Association who are not appointed to the commission itself; the chairman of each such committee in all likelihood should be a member of the commission.

The recommended new commissions are as follows: (1) Commission on Medical Education (which would combine the accreditation program, the education program and licensure), (2) Commission on Medical Service (combining the duties of the present commissions on Governmental Medical Services, Public Health, Voluntary Health Agencies, and Medical Economics and Insurance), (3) Commission on Legislation, (4) Comission on Constitution and Bylaws, (5) Commission on Public Relations (to embody the speakers' bureau, public information, and special activities) and (6) a Commission on Convention Arrangements.

To accomplish the foregoing, the following commissions would be replaced or incorporated into one of those proposed above. (1) Aging, (2) Emergency Medical Services, (3) Governmental Medical Services, (4) Interprofessional Relations, (5) Medical Economics and Insurance, (6) Public Health, (7) Public Information, (8) Special Activities, (9) Voluntary Health Agencies.

Therefore, the structure would be: Executive Committee, the Future Planning Committee, the Committee on Sports and Medicine, and the six commissions enumerated above, each consisting of seven members with approximately 10 committees of an additional four members each. The total involvement in the commission and committee structure would approximate 82 members, as contrasted with the 254 members now involved.

As to the membership of the Future Planning Committee itself, it is recommended that there be fewer ex officio members; there should be one representative who has been a president of the Association within the previous five years; one should be a student physician; another a house officer; and the additional members be selected either by the president or the Board of Trustees—not to exceed a total of 12 members.

In considering the purposes, scope of action, and goals of the committee, it is pointed out that housekeeping matters of the Association are not the proper purview of this committee. The president and the speaker should be so advised. The committee should give consideration to the needs of the Association and should hold discussions, if needed, with management consultants and should seek sources of information such as the State Board of Health, Blue Shield, and the Regenstrief Foundation in the gathering of data. Concepts should be developed as to the directions in which the Association is headed, particularly with mid-term and long-term effects. Greater participation of all physicians in the affairs of the Association should be sought as a specific objective of the Future Planning Committee.

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JOHN W. BEELER, M.D.
WILLIAM R. CAST, M.D.

Student Loan Committee

HOUSE ACTION: Ordered filed.

Recommendation: Report to be referred to the Board of Trustees, the following options to be considered: (1) Restructure of the committee (2) transfer the loan money to the AMA-ERF, and (3) discontinue the fund and/or billing for this loan committee.

No student loan applications have been received in the last four years.

To date, 108 loans, totalling $95,500, have been granted. During the last year four notes were paid in full. There are nine open notes at this time, totalling $10,883.35. No notes are in interim.

The loan fund of ISMA from 1955 to 1963 had loaned money to 118 students, in all, a total of $58,458.36. This total amount has been repaid. The Guaranteed Loan Plan with Indiana National Bank was started in December 1963, and has on deposit $20,810 of ISMA money. This guarantees loans up to $260,000.

After much discussion, evaluation of the Indiana National Bank/ISMA contract is being currently studied and further changes in loan guidelines are being considered.

A supplemental report will be made at the annual 1974 House of Delegates meeting.

MALCOLM O. SCAMAHORN, M.D.
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HUGH K. THATCHER, JR., M.D.
STEVEN C. BEERING, M.D.

Medical-Legal Review Committee

HOUSE ACTION: Ordered filed.

Article III, Section 3, of the Interprofessional Code adopted by the Indiana State Medical Association and the Indiana State Bar Association states in part:

> These appointees (three attorneys and three physicians), *if required,* will sit quarterly as a joint committee to review those court or administrative agency cases in which medical testimony appeared to the court, or administrative agency, attorney or attorneys or to the physician or physicians to have been so contradictory or improper as to indicate conscious deviation from the truth. In a like manner, they will review those cases called to their attention involving an attorney in which there is question of his exceeding propriety in his handling of medical witness, or in his efforts to introduce improper medical testimony.

There were no court or administrative actions during the past year which met the requirements of Article III, Section 3, cited above. However, the Medical-Legal Review Committee did meet on June 12, 1974, regarding several matters of interest to both medicine and law.

One of the major areas of concern is subpoenas. Numerous complaints had been received regarding the untimeliness or lack of necessity on the part of attorneys in subpoenaing doctors; and, on the other hand, the lack of cooperation on the part of physicians who have been subpoenaed. The committee indicated its desire to communicate to members of both professions those guidelines as set out in Article II, Section 5 of the Interprofessional Code regarding Subpoenas:

> It is expected that the attorney will in every instance make a good faith effort to arrange his client's expert medical evidence in ample time before the hearing to allow the physician time for special study, review, or other preparation. Such arrangements should include offer of compensation commensurate with the reasonable value of the professional services involved in preparing or offering testimony, or the time taken away from the physician's practice.
>
> In the event that medical evidence

necessary to his client's cause cannot be obtained by prior arrangement, either because the physician has held himself unavailable or has been otherwise uncooperative, then the attorney may subpoena the medical expert, and he is obligated to answer the subpoena as is any other citizen.

The committee also dealt with a request for review of a particular physician's situation involving numerous malpractice lawsuits. The basis for the request for review was suspected harassment of the physician by the attorney. After briefly looking into the matter, the committee recommended that since they have no jurisdiction until after a hearing or trial has been concluded, the matter be investigated by the staff of the local hospital.

The issue of whether to eliminate, maintain, or increase the contribution to the Medical Defense Fund was also discussed by the committee. It was the general feeling of the committee that the fund should be continued at its present level, but that the monies should also be used in the future to help secure passage of malpractice arbitration legislation.

The next major area considered by the committee was the increasing incidence of medical malpractice lawsuits and the corollary problem of increased costs and decreased access to medical liability insurance. The committee reviewed and discussed several plans for screening panels, arbitration panels, and similar approaches designed to eliminate the "nuisance" lawsuits. The committee and its staff are undertaking an in-depth study of all actual and proposed plans, both statutory and non-statutory, with the ultimate objective of preparing a proposal for Indiana. This proposal would then be undertaken on a pilot study in one of the counties in Indiana to determine its feasibility and utility for statewide application. Further information on this subject will be available at the October House of Delegates meeting.

As chairman of the Medical-Legal Review Committee, I feel obligated to impress upon each of you the importance of the medical malpractice problem. Indiana is in the crisis stage *now* regarding every aspect of medical liability. High-risk, class 5 physicians (Ob-Gyn, Anesthesiology, Plastic Surgery, Neurosurgery, Orthopedic Surgery, etc.) are being hit the hardest at the moment, but the effects are being felt by all of us. This committee is working feverishly to stave off this growing menace.

JOHN W. BEELER, M.D.
Chairman
ROBERT R. KOPECKY, M.D.
JOSEPH G. S. WEBER, M.D.
JOHN O'CONNOR
WILLIAM HALL
GEOFFREY SEGAR
JAMES J. STEWART

Reports of Commissions

Convention Arrangements

HOUSE ACTION: The Scientific program and exhibits constitute the report of this Commission. Those responsible for the program are to be commended. Filed.

Constitution and Bylaws

Bylaws

The Commission on Constitution and Bylaws is proposing the following changes in the Bylaws in order to carry out recommendations made to the Commission:

HOUSE ACTION: Adopted.

Chapter IV, House of Delegates

Be It Resolved that Sec. 7 of Chapter IV of the Bylaws be amended by striking the word "President" in the third paragraph and inserting in lieu thereof the word "Speaker." The paragraph would then read as follows:

"The Committee on Rules and Order of Business, mentioned above, shall be composed of the chairman of the various Reference Committees appointed by the Speaker."

RECOMMENDATION: The addition of a sentence of amplification after the word "Speaker" in Sec. 7, Chapter IV to read "The duties of the Speaker will be patterned after those performed by the Speaker of the AMA House of Delegates."

HOUSE ACTION: Recommendation referred to the Commission on Constitution and Bylaws as a suggestion to incorporate this sentence under Chapter VI—Duties of Officers.

HOUSE ACTION: Adopted. Elimination of Sec. 3, Chapter V.

Chapter V, Election of Officers

Section 3, Chapter V,—Any person known to have solicited votes for or sought any office within the gift of this Association shall be ineligible for any office for two years.

Sections four, five and six to be renumbered.

HOUSE ACTION: Adopted as amended.

Chapter XXXIV, Medical Defense

Be It Resolved, That Sec. 3 of Chapter XXXIV of the Bylaws be amended by striking, beginning with the second sentence, the balance of Sec. 3 and substituting the following:

In order to insure a fair and full presentation of defense for any member physician sued or against whom claim is made, the committee shall have the power to employ and pay an attorney of their choice, as a consultant to the committee, and such other expenses as the committee may approve as necessary. It is expected that the committee's consultant attorney will provide necessary communication with the member-physician's personal attorney.

Aging

HOUSE ACTION: Ordered filed.

Although the Commission on Aging has met only twice since the last annual report was filed, its members and staff have been quite active throughout the year working on medical problems of the aged and aging.

On August 8, 1973, representatives from the ISMA Commission on Aging met along with 60 other persons representing 39 organizations and agencies in the state of Indiana for the first Legislative Consortium sponsored by the Indiana Commission on the Aging and Aged. This Consortium was directed by the chairman of the legislative committee of the Indiana Commission on the Aging and Aged, Dr. W. Dean Mason.

At that first meeting, in addition to participating in workshops and discussions, the representatives from the ISMA Commission on Aging presented the "Position Statement of Medicare and Medicaid of the Commission on Aging of the Indiana State Medical Association." This position statement was readily accepted by the Consortium and was included briefly in the overall report submitted by the Consortium to the Governor. As you will recall, the position statement was prepared and presented to the House of Delegates at the 1973 annual meeting of the ISMA.

The ISMA representatives to the Consortium were also instrumental in presenting the "Death with Dignity Concept" and the idea of establishing a Gerontology Chair at the Indiana University School of Medicine.

The following legislative recommendations were accepted by the Indiana Commission on the Aging and Aged as a result of the Consortium and were presented to Governor Otis R. Bowen for possible action during the 1974 session of the Indiana General Assembly:

(1) An amendment to the Indiana School Bus Law in order to help older citizens of Indiana take advantage of public school transportation resources.

(2) A statutory amendment to permit the Annual Governor's Conference on Aging to be held on any campus of any state college or university.

(3) The adoption of better means of communication to inform older citizens regarding the features of the Indiana Probate Code.

(4) The passage of enabling legislation to allow city and county governments to appropriate funds for use by private organizations and institutions for projects designed to provide services to the elderly.

(5) That legislation be enacted to exempt the "home-delivered meals program" from Indiana State Sales Tax.

As a result of the first Legislative Consortium, the following beneficial legislative measures did pass the 1974 General Assembly: H.B. 1107, which allows school buses to be used to transport elderly people; S.B. 230, which permits governmental agencies to contract with not-for-profit organizations; and H.B. 1367, which exempts sales tax on home-delivered meals for persons who are confined to their homes.

Following the successes of the first Consortium a second Consortium was held on May 13, 1974, for the purpose of preparing legislation for the 1975 session of the Indiana General Assembly. Your commission was also represented at this meeting.

On April 21, 1974, the Commission on Aging met with Dr. J. O. Price, medical director of the Department of Public Welfare and with Mr. Al Kelly, executive secretary of the Indiana Nursing Home Association (formerly the Indiana State Welfare Director) to discuss problems of a medical nature regarding the aging population in Indiana.

At that meeting it was decided that the emphasis of the Commission on Aging should be limited to health matters of the aging population rather than being concerned with the fields of economics and social welfare. In discussing the health care problems of the aged and aging, Dr. Price pointed out that the most common complaints received by his department are

(1) Inadequate reimbursement under Title 18 and Title 19 for physician services. This is primarily due to the 75 percentile system of establishing physician's profiles. Dr. Price did point out that the profiles are reviewed and updated every July.

(2) Fear of PSRO restrictions, especially the imposition of punitive measures for failure to comply.

Mr. Kelly indicated that the major problem area in nursing homes is a failure of physicians to recertify their patients. Every patient in a skilled nursing home must be seen and recertified every 30 days. Every patient in an intermediate care facility must be seen and certified every 60 days.

The commission also voted to continue its efforts to provide for the establishment of a Gerontology Chair at the Indiana University School of Medicine. As indicated earlier in the report, this request was transmitted to the Indiana Commission on Aging and Aged.

The commission also discussed the "Quality of Life" meeting held recently in Chicago by the American Medical Association Commission on Aging. It was suggested that perhaps some of the panel members from that meeting could be invited to Indiana for a similar meeting sponsored by the ISMA Commission on Aging. At the time of this writing, this proposal is still in the planning stages.

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THEODORE R. HAYES, M.D.
MRS. C. B. LADINE

Governmental Medical Services

HOUSE ACTION: Adopted. Referred to ISMA President.

Only one meeting of the Commission was held during the past year. This came about not for lack of needs, but really because of the gasoline shortage.

The February 20, 1974, meeting was very significant, in that it pointed out the communication difficulties within federal bureaucracies and between federal bureaucracies and providers such as ISMA represents.

Apparently in 1973, Immediate Past President James Gosman's testimony at the federal hearing in Indianapolis on July 24, 1973, concerning area designation of PSROs in Indiana, was either ignored, misinterpreted or not reported to the proper bureaucracies. The hearing was called on short notice, which required Dr. Gosman to respond quickly and without benefit of counsel from commissions of the House of Delegates.

This single example is one of many pointing to the need for restructuring the commissions and committees and their relationship to the House of Delegates, Board of Trustees and Executive Committee of ISMA. It would be helpful if the House and the Board would develop not only primary policies but also contingent policies. The contingencies could be developed in detail by a group of physicians in an ongoing structure. The contingencies should be concerned with technical considerations rather than political considerations. The findings and recommendations of physicians working on technical matters should not be ignored, nor filed for information; rather they should be acted upon, with the commissions directed to develop and implement worthwhile technical projects.

The Governmental Medical Services Commission has recommended specifically for the past two years that there be an accumulation of information concerning fees, relative value studies and coding systems for procedures and diagnosis. This information is basic for evaluating ongoing and upcoming statewide proposals such as HMOs, Medicare, Medicaid, and billing of private insurance claims, either on an in- or outpatient service, and providing guidelines for our members to function effectively in this jungle of paperwork. While no specific resolutions can be offered at this time, it would be advisable, if restructuring occurs, to commission the unit of the new structure to develop these specific resolutions needed for implementation of data-gathering in utilization projects. The physicians chosen for these studies should be selected on the basis of interest and past experience, rather than on a purely geographical basis.

I wish to express my thanks to the members of the commission who served this year.

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JOHN J. DE FRIES, M.D.
MRS. JOHN STANLEY

Interprofessional Relations

HOUSE ACTION: Ordered filed.

Before reporting on the activities of the Interprofessional Relations Commission during the past year, I think it only fitting to comment on the results achieved by this commission at the close of last year under the chairmanship of Dr. Warren Coggeshall. As you will recall, the developmental stages of the Nurse-Physician Joint Practice Commission were reported in this column one year ago. Since that time, the Nurse-Physician Joint Practice Commission of Indiana has become a functioning reality. The 16-member (eight physicians and eight nurses) Joint Practice Commission has met several times during the past year and has adopted its own set of by-laws, has established numerous priorities. has received approval from the parent organizations—ISMA and ISNA, has received funding from those organizations

and has begun consideration of several of the priorities it established. Thanks to the efforts of Dr Coggeshall, his commission members and the physician members of the Joint Practice Commission, we are well on our way to establishing a better and more professional working relationship between and among physicians and nurses.

The Interprofessional Relations Commission met on three separate occasions during the past year to initiate similar dialogue with other professions. To date, the commission has met with representatives of pharmacy, dentistry and law.

In discussing the potential for better interprofessional relations with the pharmacists, the commission discussed such problem areas as the abuses of PRNs (Prescription Renewed as Needed), multiple-line prescription blanks, prescriptions without a physician's signature, and the use of name stamps. Also discussed were Patient Medication Profile Record Systems and Prescriptions for Narcotic Drugs which are signed in advance by physicians leaving on vacation.

There was strong agreement from both the commission members and the pharmacy representatives that a better system of communication between the two professions needs to be established. More specifically, the accessibility of the physician to the pharmacist needs to be improved.

The meeting with representatives of the Indiana Dental Association also raised some areas of mutual concern between the two professions. The main area of interest to the dental profession was their future role or involvement in Professional Standards Review Organizations (PSRO). The dentists strongly expressed the feeling that dental personnel must be involved in the standard-setting and policymaking decisions regarding dental practice, particularly in hospital settings. Another item of mutual concern of the two professions was the entire area of federal and state legislation. Although a good working relationship between the two professions' staffs has been enjoyed in the past, it was felt by all that a closer, more unified approach to legislative matters will be increasingly important in the future.

In meeting with members of the legal profession, the commission found that the major areas of concern to both professions dealt with problems encountered in medical malpractice litigation. Although many of the problem areas discussed are being considered by the Medical-Legal Review Committee—a joint committee composed of members of the Indiana State Medical Association and the Indiana Bar Association—the commission still felt that there were areas which could be further developed by improved communications between the two professions.

It is the strong hope of the commission that these initial endeavors will be further developed in the coming months and years and will result in the formation of joint committees similar to the Nurse-Physician Joint Practice Commission in all areas of interprofessional relationship.

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RICHARD VEACH, M.D.
MRS. OTIS BOWEN
MR. LEONARD GREEN

Emergency Medical Services

HOUSE ACTION: Ordered filed.

The Commission on Emergency Medical Services met once during the year and discussed a number of matters, with most attention given to the Indiana State Medical Association's commitment to the passage of an emergency medical service law for Indiana.

As a result of the efforts of the Commission during 1973 and into early 1974 to accomplish the mission of such passage, the bill passed, resulting in the establishment of an Indiana Emergency Medical Services Commission, with John S. Farquhar, M.D., Fort Wayne, elected as chairman of the commission.

Philip K. Martin of Lafayette, director of the State Department of Traffic Safety and Vehicle Inspection, was named executive director of the commission by Governor Bowen.

Since the organization of the Governor's Commission, it has been vigorously directing its efforts toward setting up standards for the various areas of EMS throughout the state.

The Commission wants to make note of the fact that the Governor's Conference on Emergency Medical Services, which resulted in the passage of the legislation was largely brought about through the efforts of Drs. Farquhar and Suelzer and the ISMA commission.

Other areas of concern which the Commission discussed were the status of emergency telephone number 911, the possibility of introducing a paramedic bill into the state legislature, and training for emergency medical technicians.

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ROBERT R. TAUBE, M.D.
DEBORAH ALLEN
MRS. PHILIP L. SMITH

Legislation

HOUSE ACTION: Adopted. Portion concerning Medical Practice Act referred to the Commission on Medical Education and Licensure for final perusal and to the Commission on Legislation for implementation.

Although the short (30 working days) second regular session of the 98th General Assembly will go down in history as having been a very uneventful and noncontroversial session for organized medicine in Indiana, it was a most exciting and productive session. Of the 697 bills which were introduced during this 1974 session of the General Assembly, only 159 were enacted into law. However, of the 697 bills more than 100 had a direct bearing on physicians and health care in the state of Indiana.

The Commission on Legislation carefully reviewed all of these bills at its meetings held prior to and during the session. In reviewing the bills the commission determined whether or not each bill pertaining to health care would be supported, opposed, or taken for information only. The meetings during the remainder of the legislative session after the closing date for bill introduction were used to review the progress of the bills through the legislative process.

Of the more than 100 bills which were monitored by the Commission on Legislation, 26 were enacted into law. It is safe to say that none of the 26 bills on health subjects which were finally enacted into law were opposed by the Indiana State Medical Association through the Commission on Legislation.

There were several major pieces of health legislation which were enacted into law and which were actively supported by the Commission on Legislation. A thorough recounting of these bills can be found in the June 1974 issue of the JOURNAL. However, a brief summary of those major bills is appropriate for this annual report.

S.B. 55—A Family Practice Residency Bill—was enacted into law and will provide $1,000,000 to be used in the establishment of additional family practice residencies throughout the state. S.B.

151—Emergency Medical Services Bill—was also enacted after many years of attempting to do so. This bill was probably the most significant piece of health legislation enacted in recent years. H.B. 1163—Medical Distribution Loan Fund Bill—This ISMA-written and supported bill provides for loans to medical students at the rate of $3,000 per year. $100,000 was appropriated annually for this loan fund.

The commission has met and will continue to meet throughout the interim between legislative sessions to develop a legislative program for the upcoming year. Several will be presented at the House of Delegates meeting in October for determination by the House regarding their introduction in the 1975 session of the General Assembly. One of the major pieces of legislation that the commission is currently working on is the revision of the Medical Practice Act. This bill will again be presented at the House of Delegates meeting in October.

As chairman, I would like to express my thanks for the hard work and cooperation of the members of our commission as well as the cooperation and interest shown by the legislative representatives in the various county medical societies. In addition, a debt of gratitude is owed to the many physicians who unselfishly gave of their time and energy to help support the passage of legislation favorable to quality health care and to oppose the legislation believed to be unfavorable.

DONALD E. WOOD, M.D.,
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FORREST F. RADCLIFF, M.D.
MRS. G. BEACH GATTMAN
TIMOTHY BARTH
MRS. WILLIAM RAGAN

Medical Economics and Insurance

HOUSE ACTION: Referred to Board of Trustees for consideration.

Throughout the year 1973-74, the Commission on Medical Economics and Insurance has primarily devoted its time to the ISMA insurance programs available to the membership. Currently there are four active programs—all have been implemented within the past few years; all are growing substantially; all are actuarially sound; and we have received almost no complaints on these programs. These programs are also available to corporations as well as the individual members and include: (1) Overhead Expense Plan, (2) Family Life Insurance Plan, providing protection up to $50,000, (3) Income Protection Plan, providing up to $4,500 monthly for disability, and (4) Cash Value Life Insurance Plan, which is available for those who wish to convert their ISMA Term Insurance Plan.

In addition, there currently is being offered an Excess Major Medical Plan (with either a $15,000 or $25,000 deductible amount) that provides a limit up to $250,000. Information on all of these programs is available through the ISMA office.

Additional progress has been made in the development of the Professional Liability Insurance Plan for ISMA members. As this report goes to press, the results from a survey conducted among ISMA members to determine their interest in such a program is being completed, and a supplementary report will be made at the annual meeting in October by the commission, the officers and the Board of Trustees. The action on this program followed the approval at the 1973 meeting of the House of Delegates establishing a for-profit corporation and the implementation and the approval by the officers and the Board of Trustees. It is hoped that this matter may be definitely resolved in the year 1974-75.

During the past year the Commission on Medical Economics and Insurance has considered many other problems. The following matters need special note:

A. Blue Shield.
   1. In accordance with previously expressed policy, the specific problems of individuals were referred to members of the Board of Trustees or to the Blue Shield Board members.
   2. It should again be brought to the members' attention that there does exist a mechanism whereby physicians' surgical assistants can be compensated by Blue Shield if the surgeon so indicates on his statement to Blue Shield and to the patient.

B. Standardized Health Insurance Claim Form. Although Blue Shield, Medicare, Medicaid and CHAMPUS have not approved the standardized form, the commission believed that this form should be adopted by all ISMA members in the future.

C. Workman's Compensation Insurance. This proposal for ISMA sponsorship was again proposed this past year. Due to the prevailing low premium rate and the types of coverage most physicians seem to prefer, sponsorship is not recommended. It is recommended that each physician review his insurance coverage to be sure he is protected in this area.

D. Insurance Coverage for the Newborn. The commission strongly recommends that appropriate legislation be drafted to present to the legislature to require the inclusion of this type of coverage in family policies.

E. PSRO. The commission was totally opposed to this concept and reiterates its previous position that medical peer review is the only acceptable method of review of medical activities.

F. Intern/Resident Disability Insurance. No acceptable program has been arranged to date, although negotiations are continuing.

G. Professional Liability Coverage Rates. As is well known to all ISMA members, the cost for this coverage continues to escalate rapidly. There appear to be inconsistencies in the structures but definitive information has been difficult to obtain. This area will continue to receive close scrutiny by the commission.

H. Confidentiality of Medical Records. This is a matter of great concern both as to hospital records and records in the physician's office. The practice of a few physicians in permitting outside organizations to inspect, abstract and to even copy these records is of most concern. The commission recommends that this not be permitted under any circumstances. If the patient authorization is presented for such procedure, we believe the patient should be informed of the possible consequences of such acts. The commission also realizes there is a need for pertinent information to be supplied to insurance carriers and other agencies and believes that physicians should cooperate in these areas if proper authorization is obtained. The AMA is expected to have a model law prepared for study at the clinical meeting in 1974. relating to confidentiality of medical records.

I. Liaison has been established with several specialty societies which have an interest in economic and insurance matters. It is hoped this liaison will be continued in the future.

The commission wishes to express its thanks to the ISMA staff for the cooperation and help it has received in working with the commission during the past year.

KENNETH O. NEUMANN, M.D., *Chairman*
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THOMAS J. CONWAY, M.D.
MRS. MALCOLM O. SCAMAHORN

Medical Education and Licensure

HOUSE ACTION: Ordered filed.

The commission has held four meetings during the past year. Mr. H. F. Raffensperger was appointed Coordinator for Continuing Medical Education for the ISMA with the main responsibility for supervision of the new accreditation process. The Indiana State Medical Association has been awarded a full four-year accreditation by the AMA for establishing Category I credit activities for programs offered by Indiana hospitals and other medical organizations.

The Accreditation Committee of the commission has conducted a variety of surveys and has accredited during the past six months the following hospitals and meetings of societies:

St. Joseph Hospital, South Bend
Memorial Hospital, South Bend
Deaconess Hospital, Evansville
St. Joseph Memorial Hospital, Kokomo
Reid Memorial Hospital, Richmond
LaPorte Hospital, LaPorte

The commission will also survey and accredit the annual meeting of the ISMA.

In addition, all ISMA members who have successfully completed the requirements for the AMA Physician Recognition Award have had their participation certified with a special ISMA seal and will be issued new membership cards signifying distinguished membership in the ISMA.

The commission also was instrumental in the co-sponsorship of the annual ISMA Student/Faculty Retreat which was held in March at Terre Haute. Approximately 80 individuals were in attendance. The theme was "The Physicians and Their World in 1984." Workshops and panels debated controls on medical practice, organizational changes in health-care delivery, the financing of medical care, and changes in medical education. The full report of the Retreat will again be published in THE JOURNAL of the ISMA.

The meetings of the commission featured participation by Miss Kathie Meador, president of the Indiana University Medical Student Council, and Mr. David H. Moore, an officer in the Student AMA. The commission members heard a series of special reports which included the following:

"The Department of Family Medicine" by Dr. A. Alan Fischer, professor and chairman of the Department of Family Medicine at IUMS,

"The Regenstrief Institute for Health Care" by Dr. Raymond H. Murray, professor and chairman of the department of Community Health Sciences and director of the Regenstrief Institute,

"The Activities of the State Board of Registration and Licensure" and "A Discussion on the FLEX Examination" by Dr. Merritt Alcorn, outgoing president of the State Board of Medical Registration and Examination.

Members of the commission held a series of joint sessions with the Commission on Convention Arrangements in order to prepare the scientific program for Category I accreditation, to prepare a CME exhibit, and to share in the planning for the annual meeting.

The commission again began discussion of the Medical Practice Act, with Mr. McDermott and Dr. Bryan preparing a revision for discussion by the membership of the House of Delegates at the annual meeting.

The commission unanimously voted a resolution of appreciation for Dr. Merritt Alcorn's leadership over the past eight years as president of the Indiana State Board of Medical Registration and Examination. The commission also gratefully acknowledges the participation of the Woman's Auxiliary.

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JOHN ROSCOE
MRS. WILLIS STOGSDILL
KATHIE MEADOR,
DAVID H. MOORE

Public Health

HOUSE ACTION: Ordered filed.

The commission held three meetings this year. Attendance was good and a number of subjects were dealt with:

(1) Regionalization of health departments. At each meeting this subject was part of the agenda. Dr. Andrew Offutt reported that progress was being made. Dr. Robert Yoho of the State Board of Health was invited to our meeting but was unable to make it. This subject has been of continuing interest to the commission for the last three or four years and will continue to be so.

(2) The Indiana State Board of Health coordinated Indiana Plan to Eradicate Certain Vaccine Preventable Diseases. The commission reviewed this plan and recommended that the ISMA Board of Trustees support it. The plan's long-range goals are to reduce to 10% the unimmunized or partially immunized children in each disease. The ISMA Board gave its approval to the Commission on Public Health and recommended that the staff of the ISMA notify all component societies of this action in support of the Indiana State Board of Health plan.

(3) Locum tenens relief for physicians practicing in areas where doctors are scarce, in order to permit these doctors to attend meetings and have vacations, was discussed at length. The AMA serves as a clearing house for information on locum tenens. Interested physicians may contact the AMA for information.

(4) The commission received three AMA pamphlets on Health Outreach, Free Clinics and Health Care of the Poor. These pamphlets propose more lay staff for Outreach and to attend to the social and the economic problems of the patients. Free clinics would be manned by volunteer physicians. Apparently substandard health care is available to these groups. The consensus of the commission lay in a deep awareness of these problems and the recommendation for cooperation in achieving their solution.

(5) Health care in jails was discussed in connection with a compilation of standards and materials in the publication entitled *Health Care in Jails, Prisons and Other Correctional Facilities* jointly produced by the American Bar Association and the AMA. Note was taken of the need for awareness of problems generated by and pertinent to jail operation.

(6) The National Health Policy and Health Development Act of 1974 (H.B. 12053, Rogers, Fla.). This omnibus bill of 66 pages brazenly represents federal

usurpation of activities reserved to the states pursuant to the Tenth Amendment. If enacted, this bill would effectively strangle agencies established by state law. The Commission on Public Health voted that H.B. 12053 be considered totally unacceptable and is rejected unequivocally.

(7) V.D. Program. The State of Oregon's program providing for reporting of laboratory findings, the establishment of a Governor's Task Force on Venereal Disease, and the operation of free clinics with provision of supplies therefor, was discussed. Comparison with the Indiana situation was made. Much concern was expressed regarding the VD situation in Indiana, especially in certain urban areas such as Lake County. The commission voted to produce (a) a letter suitable for mailing to all physicians to emphasize this situation and (b) information for the editor of THE JOURNAL of ISMA for his consideration.

(8) Hypertension Program. The commission concurred with the action by Dr. Joe Dukes, ISMA president, when he notified Dr. W. T. Paynter, Indiana State Health Commissioner, of ISMA's support for the Department of Health, Education, and Welfare's hypertension education program.

(9) Ear piercing in business establishments. The commission recommended to the Board of Trustees of ISMA that piercing of the ears by medically unsupervised and/or non-medical personnel may violate the tenets of the Medical Practice Act and thus place the public at undue risk. This position was approved by the Board of Trustees. Information from the Secretary of the State Board of Medical Registration and Examination later indicated piercing ears was indeed a medical procedure and subject to investigation by that Board.

(10) Traffic safety forms for physicial examination of truck drivers. The present physical examination forms for truck drivers is the only requirement these important drivers need for licensure and yet it does not reveal certain essential information about the driver, such as his use of alcohol, drugs, psychiatric treatment, or record of accidents. In the interest of traffic safety, the commission recommended that the Federal Department of Transportation and the Interstate Commerce Commission include a statement from an appropriate law enforcement agency as a part of the physical examination for truckers. Such a statement should detail any record of the applicant's past history of alcoholism, accidents, narcotic use or psychiatric disorders. Such a statement would be a licensure requirement.

(11) Rule S-1 of the State Department of Public Instruction. A letter from the Orthopedic Association of LaPorte County, Inc., on this subject was reviewed. They passed a resolution disagreeing with the requirement that for a child to be eligible for a program of special education, a physician needs to show some abnormal neurological findings. This letter was referred to the Maternal and Child Health Committee of ISMA.

(12) A number of miscellaneous subjects were noted and reviewed: the National Society for the Prevention of Blindness recommends silver nitrate for preventing ophthalmia neonatorum; that protection of the newborn's eyes is important in phototherapy; a program for medical orientation of lay driver licensure examiners; the National Cancer Society's program; booklets from the USEPA on health effects of environmental pollution; booklets on alcoholism; a plan of blood donations by relatives of recipients as practiced in the San Joaquin County Medical Society, Calif.; the procedure for handling medicines for the school child.

The chairman wishes to thank the many loyal commission members who attended meetings so faithfully and who gave of their time and mature judgment with good will and an interest in the welfare of ISMA and of the people of our state.

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ROBERT M. SEIBEL, M.D.
MRS. EDSEL REED

Public Information

HOUSE ACTION: Adopted as amended. Referred to Board of Trustees. Tel-Med to be continued until funds run out or outside funding is found.

The Commission on Public Information met December 16, 1973, February 17, April 28, and June 2, 1974.

The major work of the commission was the development of a lay speakers' bureau which will represent the Association's attitude on current medical issues. The format and budget was approved by the 1973 House of Delegates. Through the speakers of the bureau, factual reports to the people should promote understanding of the positions held by physicians concerning many socioeconomic and political matters. To date, several acceptances have been received from individual speakers. Completely managed by the Hopkins Syndicate, so as to be efficiently implemented, they will be responsible for all the development of biographical data and pictures, coordination of assignments, and for feed-back reactions from the audience. Background materials on various subjects will be provided to the speakers; however, the planning of the format of their individual talks will be in accord with each one's particular style of delivery.

Carried over from last year are plans to circularize a detailed, but simplified, questionnaire concerning activities of Association members. This is now in the implementation stage.

Also, efforts are now being made to develop a system whereby publicity and other material channeled through the ISMA office can, in turn, be sent to physicians who are close to editors and publishers in the media industry throughout Indiana. The survey is now in process and will include the names of editors, TV and radio news managers, and the names of local physicians on familiar terms with these individuals. This data is to be accumulated in the ISMA files and periodically updated.

Another ongoing successful program initiated in 1973 by the commission is the circulation of the waiting room poster, periodically mailed to interested physicians, which emphasizes health information, socioeconomic facts, and medical policies and philosophies.

The commission again this year made selections for the journalism awards and for the Physician of the Year Award. These awards are to be presented at the ISMA annual meeting in October.

A pamphlet "You and Health Insurance," originally drafted by Dr. Ahler, member of the commission, was reviewed by the Commission on Medical Economics and Insurance and is now being finally edited for printing and distribution to Indiana physicians. The pamphlet is designed to clarify for the recipient of health services the role the physician represents and the responsibility of insurance carriers.

Tel-Med, a toll-free telephone medical information service of ISMA, having been initiated for Marion County and nearby areas in April 1973, was developed into a statewide operation. The caller has a choice of 211 tape-recorded messages. The program, in terms of public relations, has received widespread favorable comment.

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Special Activities

HOUSE ACTION: Ordered filed.

During 1973-74 the Commission on Special Activities met on two occasions.

The commission was assisted in its work by two subcommittees: the Rural Health Subcommittee chaired by Dr. Richard Hawkins and the Subcommittee on Evaluation of Commissions and Committees chaired by Dr. Richard B. Hovda. The work of the latter subcommittee is still in progress.

The Rural Health Subcommittee created an Ad Hoc Study Committee, chaired by Dr. Raymond Murray, which prepared a detailed proposal for an Assessment and Assistance Program to promote improvement in the availability and accessibility of health care services for underserved rural regions in Indiana. The proposal was submitted for possible federal funding as a joint project with the Department of Community Health Sciences, Indiana University School of Medicine and the Regenstrief Institute for Health Care, Marion County General Hospital.

The objectives of the Rural Assessment and Assistance Program are:

1) To procure, correlate and store the available information on health care and related subjects which pertains to rural areas in Indiana.

2) To work with rural regions which are medically underserved and which apply for assistance for improving their health care services.

3) To develop a suitable group of practicing physicians, physicians-in-training, other health providers and interested citizens with an interest and experience in rural areas. This group will provide assessment and assistance to the identified needy areas. In addition, this group will attempt to establish criteria for medical and auxiliary professional staffing in rural areas and norms for physical facilities.

4) To promote interest in rural medical practice among medical students and physicians-in-training.

5) To serve as a placement service for physicians-in-training who are interested in rural practice.

6) To evaluate the effectiveness of this program. To achieve these objectives there will be established a Special Action Committee for Rural Health (SAC) which will be created as a subcommittee of and responsible to the Rural Health Subcommittee of the ISMA.

The system will work as follows:

1) A rural town or rural area which has a serious need for improved health care will contact the ISMA or SAC. All contacts will be referred to the SAC.

2) After approval by the SAC, the interested town will be contacted and, with representatives of that town, a plan for assessment and assistance will be prepared.

3) The SAC will bring together from its own files and elsewhere all available information on that particular region, data which concerns health care resources as well as economic, demographic and related data.

4) The SAC will create a special Task Force for the assessment of this town, provide it with relevant information available on the town and the nearby area, and instruct the Task Force.

5) The Task Force will visit the region, meet with health care provider groups and other individuals and groups relevant to the study, and prepare a comprehensive report on the region's needs and resources. This will require an undetermined number of visits. The Program Director will probably also visit the community independently as well as with the task Force.

6) With the help of the Program Director, the Task Force will prepare and submit a final report to the SAC, and they will jointly prepare and submit an assessment and recommendation to the town and initiate whatever assistance seems appropriate and feasible. This will include advice, cooperation in preparing and carrying out surveys, serving as negotiators between or among dissident factions within the community, assistance with physician placement, etc.

7) The SAC will provide periodic reports on its activities to the Rural Health Subcommittee.

8) At a suitable time, following the completion of each project, the SAC (and perhaps also the special Task Force involved), will evaluate the effectiveness of this project.

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MRS. JAMES GUTHRIE

Voluntary Health Agencies

HOUSE ACTION: Ordered filed. Further consideration to establish a mechanism whereby local agencies may be approved by county societies and thereby receive approval of the Indiana State Medical Association needs to be undertaken.

The commission met four times during the fiscal year to conduct its business relating to the voluntary health agencies of Indiana.

After review of comprehensive reports submitted by the various agencies concerning their programs and activities, the following were given approval:

American Cancer Society, Indiana Division, Inc.
American Heart Association, Indiana Affiliate, Inc.
American Lung Association of Indiana
Arthritis Foundation, Indiana Chapter
Hemophilia of Indiana, Inc.
Indiana Easter Seal Society for Crippled Children and Adults, Inc.
Indiana Society for the Prevention of Blindness
Kidney Foundation of Indiana, Inc.
Mental Health Association in Indiana
National Multiple Sclerosis Society, Indiana Chapter
Tri-State Epilepsy Association, Inc.

Following the usual pattern of organization, 14 liaison representatives from the Woman's Auxiliary, headed by Mrs. Jack Walker of Yorktown, worked with the commission and the health agencies of the state by attending meetings of the agencies and keeping abreast of their activities.

The commission, in conjunction with representatives of the state health agencies and the ISMA Woman's Auxiliary liaison members, had a very successful luncheon meeting in February. Much enthusiastic input was gained from the agencies regarding their new programs, the methods of evaluation, personal contacts, a proposed health agency booklet explaining agency purposes and services, and the new statewide Tel-Med program of ISMA.

In order to obtain more coordinated activities with the commission, three representatives from different agencies were appointed by the agencies to serve on a rotating basis as permanent non-voting members of the commission and are invited to all commission meetings.

Approximately 10,000 placards listing approved agencies were distributed this year and plans have been made to continue with the printing and distribution of placards for 1974. Additional plans are for the placard to be printed in THE JOURNAL and perforated so as to be easily extracted by physicians wanting to use it as a reference. This will be in addition to the usual listing of the approved agencies.

As examples of some of the commission's additional involvement with the agencies, the following items were considered:

The group investigated the Heart Disease Research Foundation headquartered in New York City and listed in the yellow section of telephone directories throughout the nation as accepting funds for research. Careful review of its income and expenditures was conducted and they were found to be questionable. Both the American Heart Association and the American Medical Association have incomplete data on the organization. The commission feels that contributions to this organization should be discouraged.

Additionally, the commission looked into the matter of one agency's circulating material to patients, causing some concern and consternation among physicians. In an excellent spirit of cooperation, this agency, the Multiple Sclerosis Society (one of the ISMA's approved bodies), agreed to mail the material direct to physicians.

The commission also voiced objection to the Board of Trustees of the ISMA for lending its name in support of a statewide program of an agency which was not on the approved list of organizations. The Board, after careful review of the situation, moved that henceforth it would be the policy of the Association to adhere to the recommendations of the commission concerning such support.

The commission wishes to emphasize to the House of Delegates the appreciation expressed by officials of the voluntary health agencies of the interest of the ISMA in their affairs. This, of course, is a two-way cycle with the agencies interested in the programs of the Association which in every instance affects one or more of them at any given time.

Finally, as chairman, I want to express my thanks to the members of the commission and to the agency representatives for making this past year's activities meaningful for all.

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Resolutions

Resolution No. 74-1

Introduced by: Vanderburgh County Medical Society
Subject: LEGISLATION TO DEFINE THE WORD "PHYSICIAN"
HOUSE ACTION: Adopted. Referred to Commission on Legislation

Whereas, Indiana courts have construed the word "physician" to include a person engaged in the practice of chiropractic; and

Whereas, The term "physician" is ordinarily understood by laymen to signify persons who are graduates of schools of medicine or schools of osteopathy; and

Whereas, The application of this term to graduates of schools of chiropractic is misleading as to both the amount and the quality of education of the practitioner; and

Whereas, The validity of the foregoing statements has been recognized by a formal endorsement of the Indiana State Medical Association House of Delegates in annual convention in October 1972 and again in October 1973; and

Whereas, The staff of the Indiana State Medical Association did subsequently seek to encourage members of the Indiana state legislature to redefine the legal meaning of the term "physician" through support of appropriate legislation; now, therefore, be it

Resolved, That the Indiana State Medical Association again prepare and seek to have introduced into the General Assembly a bill defining the term "physician" as applying only to persons holding the academic degree of Doctor of Medicine, or Doctor of Osteopathy.

Resolution No. 74-2

Introduced by: ST. JOSEPH COUNTY MEDICAL SOCIETY
Subject: COMPOSITION OF THE HOUSE OF DELEGATES OF THE ISMA
HOUSE ACTION: Not Adopted.

Whereas, The present Constitution of the ISMA in Article V, Section 1, states that the House of Delegates shall be the legislative and business body of the Association and shall consist of: (1) delegates, or their designated alternates, elected by the component county societies; (2) the trustees, or their designated alternates; (3) the ex-presidents of the ISMA, and (4) delegates, or their designated alternate delegates elected by their respective section. The following shall be ex officio members: the president, the president-elect, the executive secretary, the treasurer and the assistant treasurer of the Association, and the delegates to the AMA, all without power to vote, except in case of a tie, when the person presiding shall cast the deciding vote;

Whereas, The Constitution appears to intend that the House of Delegates of ISMA consist of members of ISMA elected to represent various component county societies or districts;

Whereas, The members of the House of Delegates of ISMA are elected by ISMA members of various component county societies and districts, except for officers of ISMA, who are elected by the House of Delegates, and the executive secretary;

Whereas, The president of the ISMA is elected by the House of Delegates and eventually will become an ex-president and, therefore, under the present Constitution of ISMA, will hold a life membership in the House of Delegates; a privilege denied every member, except another past president;

Whereas, The House of Deelgates of ISMA in 1973 had 156 voting members, including 16 ex-presidents, which represents 10.2% of the voting members of the House of Delegates of ISMA;

Whereas, an ex-president does not officially represent a component society or a district of the ISMA, but only himself; therefore, be it

Resolved, That Article V, Section 1, of the Constitution of ISMA be amended to include the ex-presidents of the ISMA in the House of Delegates as ex officio members without power to vote.

Resolution No. 74-3

Introduced by: Marion County Medical Society
Subject: UNIFIED AMA MEMBERSHIP
HOUSE ACTION: Not Adopted.

Whereas, Experience has shown that

medicine as a house divided is extremely vulnerable to those who would control physicians and their modes of practice; and

Whereas, Government inroads into the health care field are increasingly varied and bold; and

Whereas, A cacaphony of voices attempting to speak for medicine are unheard or dismissed as ineffective; and

Whereas, The American Medical Association, despite some shortcomings, unquestionably is the strongest influence in the national medical field and the only medical organization truly representative and effective on the national legislative scene; and

Whereas, American Medical Association programs and concerns touch upon practically every facet of medicine and its practice; and

Whereas, Only two county medical societies in Indiana, Marion and St. Joseph, require their members to be members of the American Medical Association; therefore, be it

Resolved, That the Indiana State Medical Association establish membership in the American Medical Association as a condition of membership in the Indiana State Medical Association and its component county medical societies.

Resolution No. 74-4

Introduced by: Marion County Medical Society

Subject: INCLUSION OF IMMEDIATE PAST PRESIDENT ON EXECUTIVE COMMITTEE

HOUSE ACTION: Adopted the first resolve and deferred the second resolve until 1975.

Whereas, The Executive Committee of the Indiana State Medical Association is the executive body of the Board of Trustees in the interim between meetings of the Board and frequently must make decisions for the Association; and

Whereas, The actions of the Committee represent a distillation of the wisdom, judgment and experience of its members; and

Whereas, It cannot be expected that any member of the Association could bring to the Committee more years of involvement with the affairs and problems of the Association than the immediate past president, president-elect and president; and

Whereas, Inexperience is a luxury the Association cannot afford in these trying days; therefore, be it

Resolved, That Chapter VII, Section 12, of the Constitution and Bylaws of the Indiana State Medical Association be amended to provide that each immediate past president of the Association be a member of the Executive Committee, with power to vote, during the year in which he holds such title.

Resolved, That one of the at-large members of the Executive Committee be elected by and from the House of Delegates.

Resolution No. 74-5

Introduced by: Vigo County Medical Society

Subject: ISMA OFFICERS MANDATED TO OPPOSE PSROs

HOUSE ACTION: Not adopted.

Whereas, The House of Delegates at the 1973 Indiana State Medical Association Convention voted unanimously to oppose the concept of PSRO and to work diligently for the repeal of the PSRO laws; and

Whereas, The delegates interpreted this vote as a mandate for elected and appointed officers of the Indiana State Medical Association to continue to act on their behalf until such time as a change was authorized by a called session of the House of Delegates; and

Whereas, The Board of Trustees of the Indiana State Medical Association rejected a government grant to form a support committee to study PSRO; therefore, be it

Resolved, That until such time as the official stand of the majority of the members of the Indiana State Medical Association, as expressed by the vote in the House of Delegates, be changed, that the elected and appointed officers of the Indiana State Medical Association be instructed to continue to follow that mandate; be it further

Resolved, That any officer or appointed official of the Indiana State Medical Association who associates him or herself with any group that is working outside the Indiana State Medical Association to obtain funds from the federal government to support a study of PSRO be asked to either publicly disassociate themselves from such a group or be asked to resign from their elected or appointed office in the Indiana State Medical Association; and, be it further

Resolved, That a copy of this resolution be sent to the headquarters of the Indiana State Medical Association, the Board of Trustees, and all county medical societies and also sent to the House of Delegates for action at the next state convention.

Resolution No. 74-6

HOUSE ACTION: Following Substitute Resolution No. 74-6 adopted in lieu of Resolutions No. 74-7, 74-8, 74-9, 74-14 and 74-22, as amended. Referred to the President of Indiana State Medical Association.

Whereas, The AMA House of Delegates' action in June 1974 not to recommend repeal of PSRO (Secrion 249F, P.L. 92-603) was taken without the benefit of debate on the floor of the AMA House of Delegates; and

Whereas, Parliamentary maneuvering by the AMA leadership to prevent a floor debate of a PSRO recommendation was evident; and

Whereas, There has been voluminous testimony from Indiana physicians expressing dissatisfaction and frustration over the failure of the AMA to continue to work for the repeal of PSRO; therefore, be it

Resolved, A letter expressing disproval of the lack of free debate on the floor of the House of Delegates of the AMA be written by the president of the ISMA.

Resolution No. 74-10

Introduced by: Board of Trustees

Subject: USE AND ACCEPTANCE OF THE STANDARD AMERICAN MEDICAL ASSOCIATION'S CLAIM FORM BY INSURANCE CARRIERS DOING BUSINESS IN INDIANA

HOUSE ACTION: Adopted. Board of Trustees of ISMA to direct each member of the Blue Shield Board to accept claims regardless of the form, if it contains the necessary pertinent information, which the other insurance companies are accepting at the present time.

Whereas, Physicians are constantly required to fill out insurance report and claim forms from many insurance commercial insurers; and

Whereas, The insurance carriers have not standardized their report claim forms, thereby serving to confuse the physician and unduly complicate his work; and

Whereas, The American Medical Association has standardized a form which should be satisfactory to the physician and the commercial insurer; therefore, be it

Resolved, That the Indiana State Medical Association take whatever action is necessary to make it compulsory that insurance carriers doing business in Indiana use and accept the standard claim form for physician and patient claims and reports in this State.

Resolution No. 74-11

Introduced by: Committee on Future Planning

Subject: ANNUAL MEETING

HOUSE ACTION: Adopted.

Whereas, Several state medical associations hold their annual meetings concurrently with the meetings of state specialty societies; and

Whereas, The Indiana Society of Internal Medicine and the Indiana Chapter of the American College of Physicians have held their annual meetings jointly during the annual ISMA convention with resultant benefits in attendance and quality of programs; and

Whereas, economies of time and effort could result for more of the physicians of Indiana by combining the meetings of the statewide professional medical societies; and

Whereas, facilities for achieving this are now available; be it

Resolved, that ISMA schedule its Annual Meeting so that the scientific sessions not conflict with business meetings of the association; and be it further

Resolved, That negotiations be initiated with the Indiana Academy of Family Physicians, the various other state specialty societies and the Indiana University School of Medicine to develop a coordinated scientific and educational annual program of meetings during one period of time, which would be preceded and/or followed by the business activities of the various organizations, with enhancement of effectiveness and benefits, together with promoting understanding and cooperation among all segments of Hoosier medicine.

Resolution No. 74-12

Introduced by: George T. Lukemeyer, M.D., Delegate from Marion County

Subject: CREATION OF A SECTION ON CLINICAL PHARMACOLOGY AND THERAPEUTICS

HOUSE ACTION: Not Adopted. Recommendation that this resolution not be adopted until such an organizational program can be presented to the 1975 House of Delegates.

Be it resolved, That Chapter III, Section 1 of the Bylaws, be amended by adding a new line "r" to read "Clinical Pharmacology and Therapeutics"; and be it further

Resolved, That the present line "r" be relettered line "s."

Resolution No. 74-14

Introduced by: Perry County Medical Society

Subject: IMPAC MEMBERSHIP

HOUSE ACTION: Adopted as amended.

Whereas, The medical profession's future is daily affected by federal legislation; and

Whereas, IMPAC and AMPAC have been effective organizations in electing candidates and influencing legislation favorable to medicine and patient care; now, therefore, be it

Resolved, That all members and especially officers and members of board and delegates of ISMA be urged to also join IMPAC and AMPAC and endorse its objectives.

Resolution No. 74-15

Introduced by: Vanderburgh County Medical Society

Subject: PUBLICITY ON MALPRACTICE ACTIONS

HOUSE ACTION: Not adopted.

Whereas, Articles appear frequently in the news media describing malpractice suits which have been brought against physicians; and

Whereas, The details described in these articles are allegations based upon the patients' complaints rather than the findings of a court or jury, and may not necessarily even be based upon fact; and

Whereas, In many of the cases there is no investigation of the record by the attorney prior to the filing of the suit; and

Whereas, Enormous damage may be done to physicians who are known to those reading such articles by unsubstantiated charges; and

Whereas, The State of Pennsylvania requires that the plaintiff who is claiming unliquidated damages state only whether the amount claimed is more or less than $10,000; and

Whereas, The State of California allows the defendant in a malpractice action to require the plaintiff to post a surety bond or cash to cover the cost if a complaint is frivolous; now, therefore, be it

Resolved, That the Indiana State Medical Association House of Delegates direct the Board of Trustees and staff of the Association to cause to be prepared a bill for introduction into the Indiana State Legislature which would help subdue the sensational aspects of the of publicizing malpractice action.

Resolution No. 74-16

Introduced by: Vanderburgh County Medical Society

Subject: EVALUATION OF COMPETENCY

HOUSE ACTION: Adopted.

Whereas, Proposals for national licensure and preriodic relicensure of physicians are now being advanced in the Congress; and

Whereas, Several states have already enacted medical relicensure statutes; and

Whereas, Most specialty boards are in the process of developing recertification procedures; and

Whereas, The art and the skills of experienced practitioners within the boundaries of their self-defined limits of practice cannot be properly evaluated by standardized examinations of cognitive information; and

Whereas, Precipitate, ill-advised measures intended to maintain professional competence could produce diversions of health manpower counter-productive of the desired benefits; now, therefore, be it

Resolved, That well-designed methods of professional peer review emphasizing evaluation of performance rather than the ability to score on examination of knowledge be endorsed as the best means of appraising competence in providing medical care; and, be it further

Resolved, That the Indiana State Medical Association communicate these concerns, with suitable supporting data, to all candidates for the state General Assembly and the national Congress, and regularly remind these legislators of such concerns; and, be it further

Resolved, That the ISMA delegation to the American Medical Association sponsor appropriate measures to see that the AMA implement these objectives.

Resolution No. 74-17

Introduced by: Vigo County Medical Society

Subject: TO MAKE PROPER INTEREST CHARGES ON OVERDUE ACCOUNTS

HOUSE ACTION: Adopted as amended.

Whereas, To prevent rising costs for medical care remains the goal of practicing physicians; and

Whereas, Such cost control is best assured by careful budgeting and practice planning methods; and

Whereas, Prompt collection of fees for services rendered to patients able to pay is necessary for such budgeting methods —even more obviously when inflation quickens time's erosion of values; now, therefore, be it

Resolved, That the House of Delegates of the Indiana State Medical Association affirm the professional correctness of interest charges imposed on overdue medical bills, and instruct the delegates to the AMA to express this sentiment to the national organization.

Resolution No. 74-18

Introduced by: Martin J. O'Neill, M.D., Valparaiso

Subject: COMPOSITION OF AMA COUNCIL ON MEDICAL EDUCATION

HOUSE ACTION: Not adopted.

Whereas, The Bylaws (Chapter XI, Sec. 2. Paragraph (B) of the American Medical Association provide that membership of the Council on Medical Education shall consist of ten active members, at least one of whom shall represent private practice and have no academic connections; and

Whereas, This has been taken literally over a period of many years with the result that the Council has become dominated by academicians to the point it is virtually a A. A. M. C. appendage; and

Whereas, As a result, the community hospital graduate education programs, where the majority of trainees are, and the majority of physicians are, have all but been excluded from having a voice in medical education during these critical times; now, therefore, be it

Resolved, That the Indiana State Medical Association House of Delegates instruct its delegates to the American Medical Association to introduce a resolution at the next meeting of he A. M. A., calling for a change in the A. M. A. Constitution and Bylaws to provide the following: "The Council on Medical Education shall consist of ten active members, *of which not less than one nor more than five shall be a member of a medical school faculty nor a member of the staff of a hospital associated with a medical school or university.*

Resolution No. 74-19

Introduced by: Putnam County Medical Society

Subject: PSRO

HOUSE ACTION: Adopted.

WHEREAS, The membership of the Indiana State Medical Association is unalterably opposed to PSRO; and,

WHEREAS, under the Principles of Medical Ethics to which we all subscribe, it says that "doctors should obey all laws"; and,

WHEREAS, P.L. 92-603 is now the law of the land; now, therefore, be it

RESOLVED, That the Indiana State Medical Association join with the American Medical Association and other states in an effort to eliminate the objectionable features of P.L. 92-603 until such time as actual repeal is possible.

Resolution No. 74-20

Introduced by: David Ryan, M.D.

Subject: DATA HANDLING

HOUSE ACTION: Adopted. Referred to the Board of Trustees.

WHEREAS, P.L. 92-603 is the law of the land and, until such time as it is repealed or extensively amended, physicians in the State of Indiana will encounter its effects; and

WHEREAS, Other purchasers of medical care including intermediaries and insurance carriers are demonstrating increased interest in data collection pertaining to utilization review and medical care evaluation; and

WHEREAS, Through these and other activities various types of data extraction, storage and processing of material from the patient record will be accomplished; and

WHEREAS, Physicians have traditionally and appropriately accepted responsibility for the confidence of their patients' record, and that a continued, effective doctor/patient relationship is dependent on the physician's exercise of that obligation; therefore, be it

RESOLVED, That no member of the Indiana State Medical Association will participate in or authorize the extraction or transfer of his or her patients' clinical data until and unless the following safeguards are provided:

1. Access to stored patient data is absolutely determined by physicians accountable to the Indiana State Medical Association.
2. Assurance of data validity, design and extent of processing programs and the format and distribution of reports be managed by physicians accountable to Indiana State Medical Association.

Resolution No. 74-21

Introduced by: Jackson-Jennings County Medical Society

Subject: LEGAL ACTION CHALLENGING THE CONSTITUTIONALITY OF PUBLIC LAW 92-603 SECTION 249 F (P.S.R.O. LAW)

HOUSE ACTION: Referred to the Board of Trustees for study without any action by the House of Delegates.

Whereas, The Indiana State Medical Association has repeatedly affirmed its position for repeal of PSRO through action of the House of Delegates and the Board of Trustees and in testimony before the Subcommittee on Health of the Finance Committee of the United States Senate; and

Whereas, The PSRO law provisions constitute an unreasonable interference with the right of a physician to engage in the private practice of medicine, and, therefore, is violative of the Fifth Amendment of the United States Constitution; and

Whereas, The PSRO law will engender an unreasonable invasion of the right of privacy, protected by the Ninth Amendment of the United States Constitution; and

Whereas, The AMA has failed to act for repeal of PSRO; therefore, be it

Resolved, That the Indiana State Medical Association through its elective officers and with appropriate legal counsel, join suit with other medical groups or bring suit independently to seek to have the PSRO law declared unconstitutional.

Fiscal Note: It is recommended that $2,500 be taken out of the Speakers' Bureau Fund and appropriated for this purpose.

Resolution No. 74-23

Introduced by: The Marion County Medical Society

Subject: HONORARY MEMBERSHIP
Arthur G. Loftin, former executive secretary, Marion County Medical Society

HOUSE ACTION: Adopted.

Whereas, Arthur G. Loftin has served with distinction as the executive secretary of the Marion County Medical Society for 17 years; and

Whereas, He has earned the respect and admiration of all the members of the Marion County Medical Society and of other physicians and Executive Directors and/or Secretaries of other Societies throughout the state of Indiana, and

Whereas, The Marion County Medical Society has, by due process, elected him an honorary member of the Marion County Medical Society; now, therefore, be it

Resolved, That this House, in accordance with Article IV, Sec. 6 of the Constitution of Indiana State Medical Association, unanimously elects Arthur G. Loftin an honorary member of Indiana State Medical Association because of the highly meritorious service he has rendered to the profession of medicine in Indiana.

Resolution No. 74-24

Introduced by: The Marion County Medical Society

Subject: AETNA LIFE AND CASUALTY INSURANCE COMPANY COMMUNICATIONS IN REGARD TO CLAIMS REVIEWED BY MEDICAL SOCIETY COMMITTEES

HOUSE ACTION: Not adopted.

Whereas, Over time, in its communications with policyholders whose claims it has requested the Insurance Committee of the Marion County Medical Society to review, the Aetna Life and Casualty Insurance Company frequently has misunderstood, misinterpreted, or distorted the

committee's conclusions, and

Whereas, The company's communications policy has differed little from that, in the past, which promoted resolutions of protest to the House of Delegates of the American Medical Association, and

Whereas, That policy has confused patients and engendered suspicion of the medical profession and deterioration of the physician-patient relationship; now, therefore, be it

Resolved, That insurance claims review committees of the component medical societies of the Indiana State Medical Association decline to review claims for the Aetna Life and Casualty Insurance Company until ISMA and Aetna representatives can develop a memorandum of understanding which will correct the adversary relationship which prevails.

Resolution No. 74-25

HOUSE ACTION: Following Substitute Resolution No. 74-25 adopted in lieu of Resolutions No. 74-25 and 74-26, as amended

Subject: MEDICAL LIABILITY INSURANCE

Whereas, Most insurance companies which once wrote medical liability insurance for physicians have discontinued such coverage; and

Whereas, That situation has stemmed from some of the astronomic awards given to plaintiffs and litigation against doctors; and

Whereas, Malpractice premiums have created a health cost crisis with premiums for some medical specialists at a level of $23,000 per annum; and

Whereas, In many specialties this represents a major overhead cost of conducting a practice and results in increased charges to the patient; and

Whereas, The cost and the difficulty in obtaining malpractice coverage discourages and in some cases prevents young physicians from entering into clinical practice of medicine, thus resulting in the loss of physicians to neighboring states; and

Whereas, Inability to obtain such insurance soon will affect the service available in hospital emergency rooms and even now has resulted in curtailment of in-hospital surgery; and

Whereas, The resultant defensive medicine is resulting in otherwise unnecessary laboratory and x-ray studies, thereby contributing significantly to the cost of medical care and the plight of the patient; and

Whereas, There are a multiplicity of alternative actions that could be taken by organized medicine to alleviate the urgent dilemma thus requiring expert consideration such as a no-fault insurance arbitration either binding or non-binding; ceiling on financial awards to plaintiffs in malpractice actions, filing of a plaintiff bond and possible formation of our own state insurance company; therefore, be it

Resolved, That the House instruct the Board of Trustees to work with a presidentially appointed ad hoc committee to gather information with recommendations within thirty days to be acted upon definitely at a special open meeting of the Board of Trustees within sixty days, and further

Resolved, That a dues increase of $10.00, payable one time, be marked to fund the publicity and legal activity.

Resolution No. 74-27

Introduced by: Lawrence County Medical Society

Subject: REVISION OF BLUE CROSS-BLUE SHIELD REGIONS

HOUSE ACTION: Referred to the Committee on Insurance

Whereas, Blue Cross and Blue Shield has divided the state of Indiana into multiple regions in which physicians' fees and patient receipts vary for identical services; and

Whereas, the membership of Blue Cross-Blue Shield pay similar premiums through the state for similar policies and benefits; and

Whereas, the cost of supplying physicians' services is uniform throughout the state; now, therefore, be it

Resolved that the system of multiple areas with varying fees for similar services be abolished, and that benefits become uniform and a single schedule of payments applied to the entire state; and be it

Resolved that the membership of the Blue Shield Board be instructed by the House of Delegates to proceed to carry out this resolution with all possible haste.

Resolution No. 74-28

HOUSE ACTION: Deleted from Supplemental Report of Chairman of the Board

Whereas, Tel-Med has been a popular and educational device; and

Whereas, This communication reflects favorably upon the Indiana State Medical Association and its members, especially in public relations; and

Whereas, The continuation of this program and its financing will fall entirely upon the Indiana State Medical Association; therefore, be it

Resolved that Tel-Med be continued on a year-to-year basis and that dues be increased $20.00 per member to fund this program.

Resolution No. 74-29

HOUSE ACTION: Adopted

Whereas, There has been an increase in expenses for the officers, AMA meetings and the Board meetings; and

Whereas, Thrift has always been exercised to the limit; therefore, be it

Resolved to cover these necessary expense increases the dues be raised by $3.00 per member.

Resolution No. 74-30

HOUSE ACTION: Adopted

Whereas, The cost of living has increased for ISMA employees who have not been given commensurate raises for a period of years; and

Whereas, The additional employment of personnel was mandated by the 1973 House of Delegates; and

Whereas, Other administrative expenses have been on the rise; therefore, be it

Resolved that the dues be increased in the amount of $15.00 per member to cover the above expenses.

Resolution No. 74-31

HOUSE ACTION: Adopted

Whereas, A scientific journal and organ of communication is necessary to ISMA; and

Whereas, There has been increase in the expense of publication; now, therefore, be it

Resolved that the dues be increased by $2.00 per member.

Resolution No. 74-32

From: Report of the Special Reference Committee

HOUSE ACTION: Adopted

Resolved, That the House instruct the Board of Trustees to work with a presidentially appointed ad hoc committee to gather information and come forth with recommendations within 30 days to be acted upon definitely at a special open meeting of the Board of Trustees within 60 days, and further

Resolved, That a dues increase of $10, payable one time, be marked to fund the publicity and legal activity.

Report of the Special Reference Committee

The Special Reference Committee on Medical Liability met in Room 210 of the Convention Center. It was felt that the Reference Committee had good attendence considering the short notice of the meeting. The speakers were called upon by President-Elect Wilhelmus and presented to the Committee and the audience the following opinions:

Mr. Allen, Insurance Commissioner, stated that he was becoming more aware of the probelm and he needed more data regarding the magnitude of the problem and any suggestions as to how his office might solve this problem.

Mr. Stewart, attorney for ISMA, stated that in his opinion the final solutions would have to come through legislation perhaps involving binding arbitration and/or removing the action from the tort system. He felt that a constitutional bill could be written but that passage of such a bill would always be a question mark. His consultations with other law firms have indicated the legislative costs to be in the neighborhood of $20,000.

Mr. Segar, attorney, stated that the number of cases in Marion County had increased 500% in the last two years and also noted that a plantiff bar had been formed. He felt that the crisis was not completely recognized by the profession or public and recommended that immediate legislation be drafted and that this special action be taken within 90 days.

Mr. MacLennan, who is associated with Group Insurance, stated that 31 states have state medical insurance plans; however, all of the current carriers of those plans have declined to serve in Indiana.

Mr. Moeller, Medical Protective Company, answered many questions and indicated that approximately 20 suits per month are being filed with the current ability to resolve them at a rate of only 5 per month. He recommended immediate action with the goal of legislation.

Mr. Stimpson of the Illinois Group Plan noted that the Illinois Plan involved a five-year commitment of 60% of the medical association with a built-in rate increase of 15% per year to be reviewed and ultimately based on the experience rate. He felt that Indiana's special problem was that there is a small number of MDs and that a single carrier in Indiana already underwrote 60% of the preferred risks.

Numerous speakers were heard from the floor, reporting on the problem in their area. Of special note is the fact that one Indianapolis emergency room is planning to close its doors as it is at present not able to get coverage for its doctors and that anesthesia groups are finding converage impossible to obtain as well as being unable to attract any new MDs to practice in Indiana. It appears that many county hospitals will have to close their surgeries.

It is apparent that increased premium costs are at present being passed on to the patient in the form of higher fees and the practice of defensive medicine.

RECOMMENDATION

The recommendation of the Committee is that the report of Reference Committee No. 4 be adopted with the following amendment:

Resolved, That the House instruct the Board of Trustees to work with a presidentially appointed ad hoc committee to gather information and come forth with recommendations within 30 days to be acted upon definitely at a special open meeting of the Board of Trustees within 60 days; and further

Resolved, That a dues increase of $10, payable one time, be marked to fund the publicity and legal activity.

Expansion of Existing Headquarters Building

HOUSE ACTION: Adopted the portion of the report providing space for storage and non-ISMA operation in the Association's rental properties.

The Building Committee of the Association has been for the past year studying the physical plant needs of the Association's Headquarters building. The increased use of the building, increased activities of the Association and the anticipated further increases in activities necessitate the Association doing something about the additional space.

The Board authorized the Building Committee to employ an architect and, after interviewing several, selected the architects for the original building, namely, Lennox, Matthews, Simmons & Ford, Inc. The architects presented two proposals to the Board.

When the original building was constructed the lack of funds necessitated many economies being used and the footings in the existing building had to be changed so that additional stories could not be added to the existing structure. The original plans called for such possible future expansion space and anticipated an auditorium under the existing board room, and an elevator shaft was installed for possible adding onto the existing structure. However, in order to add additional stories to the existing building, it would mean developing a structural framework on the outside of the existing structure to carry any additional floors.

The architects pointed out this would be a very expensive construction and recommended a 16,000 square foot addition, consisting of a basement and main level floor, and so constructed to accommodate two additional stories if and when needed. This addition can be constructed at an approximate cost of $500,000, or a per square foot charge of $28.47. They have also presented an alternative plan which would be a much smaller addition, and the estimate on the smaller building is $407,000 plus, at an average cost of $32.76 per square foot.

The Board of Trustees has wrestled with this problem and it is evident that we do need additional space, and, therefore, are presenting this to the House of Delegates for their opinion and action.

It would mean that the Association would have to borrow $290,000 as there is only $210,000 available for building construction in the building fund.

The other alternative would be for the Association to use one of the residence buildings on Pennsylvania Street at the rear of the existing building. We are getting $185 per month out of the one property which might be used, and it has been discussed with the zoning board and at the preliminary discussion they stated they would oppose rezoning this area for commercial use, but might grant us a variance for a period not to exceed three years.

It is conceivable that we could move the CHAMPUS Department and perhaps the Tel-Med operation out of the existing building into one of these houses, and we would be reimbursed for the space occupied by the federal government on actual-cost basis, which would be less that $185 per month.

At the present time the employees are practically sitting in each other's lap. Supplies necessary to be stored are stacked in the hallways, even some of the meeting rooms are being used occasionally for other purposes.

We realize that this report is being received by you at a late date, but we would hope that the House would thoroughly study our situation and give us guidance as to which course we should follow.

Presidental Resolution

HOUSE ACTION: Adopted by acclamation.

Whereas, The 125th Annual Convention of the Indiana State Medical Association is now concluding, and

Whereas, 125 years of organized medicine in Indiana has witnessed the great changes which have taken place in the practice of medicine as changes have occurred in every facet of human endeavor; and

Whereas, These changes in the form of ever-increasing demands on the profession, some acceptable and others ob-

jectionable, continue to grow with more rapidity; and

Whereas, These times demand the utmost from the leadership of an organization, and especially its president; and

Whereas, The president of the Association this year has continued the pattern of his predecessors and has guided the organization through some perilous areas for the medical practitioner in Indiana; now, therefore, be it

Resolved, That this House of Delegates express their thanks and appreciation to Joe Dukes, M.D., for his commitment to his office and to the practice of medicine.

RESOLUTIONS OF APPRECIATION

Resolution to Donald E. Wood, M.D.

HOUSE ACTION: Adopted by acclamation.

Whereas, Donald E. Wood has for many years given of his talents, time and self in the interest of organized medicine, first at the county level, then the state and finally serving as its president; and

Whereas, Donald E. Wood has for many years served ably for ISMA as Delegate, commission member and most lately as Trustee of the American Medical Association; now, therefore be it

Resolved, That this House of Delegates, on behalf of the entire ISMA, spread on the minutes of this meeting their profound gratitude to both Don and his gracious sharing wife Betty and that this gratitude not be forgotten. Don is and always has been a gentlemen and when you say this about a man you have said it all. It is our sincere hope that Don will continue to serve medicine and the ISMA in his efficient manner.

Resolution to Eugene F. Senseny, M.D.

HOUSE ACTION: Adopted by acclamation.

Whereas, Eugene F. Senseny, M.D., has labored long and hard in the vineyards of organized medicine and has represented well this state organization as AMA delegate and as floor leader of the Indiana delegation, and

Whereas, Eugene F. Senseny, M.D., has voluntarily decided to retire from his official duties in organized medicine as AMA delegate; be it therefore

Resolved that this 125th House of Delegates of ISMA officially express its graditude and appreciation for his eight years of dedication and service to ISMA and Indiana medicine.

Resolution to Kenneth O. Neumann, M.D.

Whereas, K. O. Neumann, M.D., has declined to seek re-election as alternate delegate to the AMA; and

Whereas, He has devoted himself and his energies to the level of above and beyond as a delegate to this House, a councilor, chairman of the Council, president of this Association, and alternate trustee to the AMA—a series of trusts that span many years; and

Whereas, He has earned a lasting place in the affection of all of us; now, therefore, be it

Resolved, That this House unanimously endorse this resolution of commendation and express our sincere and deep appreciation to Ken; and further

Resolved, That an appropriate facsimile of this resolution be prepared and presented to him.

Resolution to Staff and Facilities

HOUSE ACTION: Adopted by acclamation.

Whereas, The 125th Annual Convention of the Indiana State Medical Association has been a milestone event for organized medicine in Indiana; and

Whereas, The convention has been a successful one through the cooperation of the staffs of the Convention Center, the Hilton Hotel, and the Columbia Club; and

Whereas, No convention can successfully function without such excellent facilities and cooperation; and

Whereas, The staff of the Indiana State Medical Association has labored long and conscientiously to make this Convention the success that it is; now, therefore, be it

Resolved, That this House of Delegates extend their thanks to the ISMA staff; and be it further

Resolved, That the House extend their thanks to the city of Indianapolis and to the above-mentioned facilities for their hospitality and cooperation.

Place of Future Annual Conventions

1975—French Lick—October 18-23
1976—Indianapolis—October 9-14
1977—Indianapolis—October 10-14
1978—French Lick—October 14-19
1979—Indianapolis—dates to be set by Board of Trustees

Adjournment

The House of Delegates adjourned sine die, at 3:40 p.m., Tuesday, October 8, 1974.

In Appreciation

Listed below are the firms that participated in our 125th Annual Meeting by presenting a technical exhibit, thereby enhancing the educational qualities of our meeting and providing financial support. To them we extend this recognition and a hearty "Thank You!"

May we also suggest that you retain this listing and express your personal appreciation when their representatives call upon you.

ABBOTT LABORATORIES, North Chicago, Ill.

AMS OF INDIANA, INC., Indianapolis

AMES CO., DIV. MILES LABORATORIES, INC., Elkhart

BAKER BROTHERS SALES & RENTALS, Indianapolis

BEST BUSINESS PRODUCTS, INC., Indianapolis

BLUE SHIELD OF INDIANA, Indianapolis

BRISTOL LABORATORIES, Syracuse, N.Y.

CENTRAL BRACE & LIMB CO., INC., Indianapolis

THE CENTRAL PHARMACAL COMPANY, Seymour

COULTER ELECTRONICS, INC., Indianapolis



THE EMKO COMPANY, St. Louis

ENCYCLOPAEDIA BRITANNICA, INC., Chicago

FELD PRINTING COMPANY, Cincinnati

GENERAL MEDICAL INDIANA, Indianapolis

GRAHAM ELECTRONICS, Indianapolis

HAFFNER X-RAY CO., INC., Noblesville

HOECHST PHARMACEUTICAL, INC., Somerville, N.J.

HOMEMAKERS, INC.—UPJOHN, Indianapolis

IMMKE CIRCLE LEASING CO., Columbus, Ohio

INDIANA BELL TELEPHONE COMPANY, Indianapolis

INDIANA BRACE SHOP, INC., Indianapolis

INDIANA HEALTH CARE COMPUTER CENTER, Indianapolis

INDIANA REHABILITATION SERVICES, Indianapolis

LAKESIDE LABORATORIES, INC., Milwaukee, Wis.

ELI LILLY AND COMPANY, Indianapolis

MEAD JOHNSON LABORATORIES, Evansville

THE MEDICAL PROTECTIVE COMPANY, Fort Wayne

MEDICO ELECTRONIC, INC., Indianapolis

PARKE, DAVIS & COMPANY, Detroit

JOHN H. PAYNE AUDIOLOGICAL SERVICE, Indianapolis

PHONE-A-GRAM SYSTEM, INC., San Francisco

PHYSICIANS PLANNING SERVICE CORPORATION, Indianapolis

A. H. ROBINS COMPANY, Richmond, Va.

SAFEGUARD BUSINESS SYSTEMS, INC., Indianapolis

SANDOZ PHARMACEUTICALS, East Hanover, N.J.

W. B. SAUNDERS COMPANY, Philadelphia

CLAYTON L. SCROGGINS ASSOCIATES, INC., Cincinnati

SMITH KLINE & FRENCH LABORATORIES, Philadelphia

STUART PHARMACEUTICALS, DIVISION OF ICI UNITED STATES, INC.

SYNTEX LABORATORIES, INC., Palo Alto, Calif.

TRAUB AND COMPANY, INC., Indianapolis

USV PHARMACEUTICAL CORPORATION, Tuckahoe, N.Y.

VAN AUSDALL & FARRAR, Indianapolis

WALNAT COMPANY, Indianapolis

HAROLD J. WESTIN AND ASSOCIATES, INC., St. Paul, Minn.

Scientific Grants Were Received From

ELI LILLY AND COMPANY, Indianapolis

A. H. ROBINS COMPANY, Richmond, Va.

THE UPJOHN CO., Kalamazoo, Mich.

MERCK SHARP & DOHME, Chicago

COMMERCIAL ANNOUNCEMENTS

FAMILY PRACTITIONERS

Excellent opportunity to thrive in a group setting. Premium financial reward. Partnership in one year. Great investment opportunities. Fringe benefits. Healthy active community with good schools located in northwest Indiana. Please contact: W. V. Hehemann, M.D., Department of Family Practice, The Hammond Clinic, 7905 Calumet Avenue, Munster, Ind. 46321.

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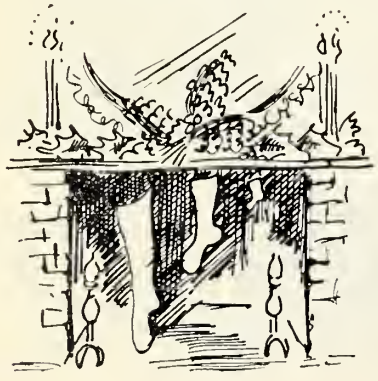
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